Joint Appraisal Report

Country	KENYA
Reporting period	*August 2015 Initial appraisal*
cMYP period	*2013-2017*
Fiscal period	*July– June*
Graduation date	*N/A*

1. EXECUTIVE SUMMARY

1.1. Gavi grant portfolio overview

The Kenya constitution has devolved political power and governance to two levels of government, National and 47 newly created and semi-independent counties that are led by elected Governors and 1,450 ward representatives with clearly defined functions. Health including Immunization service delivery is a devolved function with national government procuring vaccines and providing oversight for standards and quality through legal and policy development and enforcement. Since 2013, the country has faced challenges in timely financing for procurement of vaccines and declined financial support for service delivery due to underfunding and delayed financing by both national and county governments. The EPI program is currently supported technically and financially by Gavi, WHO, UNICEF, CDC, CHAI, USAID/MCSP. Of these sources, the biggest proportion has been from Gavi whose immunization expenditure to Kenya in 2014 constituted 46% of the total, followed by other partners at 45% and government at 9% (APR 2014). Expenditure trends over the past three years show a general decrease in government support from 20% (2012) to 9%(2014), an increase in partner support from 9% to 45% and from Gavi, a decline from 71% to 46%.Gavi supported immunization through Vaccine introduction grants, cash support for HPV project and direct new vaccines procurement. The government of Kenya procures all traditional vaccines from its own resources, co-finances new vaccines and is in charge of operational costs(HR, maintaining infrastructure and other overheads). Limited financial support is provided for operations.

Gavi provides the largest financial support to the immunization program. To date, Kenya has received USD 344,392,856 of which USD 26,178,992 was received to support procurement and introduction of the following new vaccines: Penta, YF, PCV 10, HPV (Demonstration project) and Rotavirus. The program has increased engagement with CSO through HENNET, an umbrella organization that brings together CSOs. Financing for CSO for immunization however remains very limited. Kenya will apply for Gavi HSS grant in January 2016 that will help address existing challenges including providing support to the CSO platform in Kenya.

1.2. Summary of grant performance, challenges and key recommendations

Grant performance (programmatic and financial management of NVS and HSS grants)
With support from Gavi, Kenya introduced Pentavalent vaccine in 2002, Yellow fever vaccine in 4 districts since 2002, PCV 10 in 2011, and HPV demonstration project in 1 county in 2013, and Rotavirus vaccine in July 2014. According to JRF2014, 81% of the target population received three doses of Penta vaccine, 80% PCV10, 40% Rota. HPV vaccine demonstration

project that was conducted in one county ended early 2015, with a recorded coverage of 96% and 86% in the first and second year of the project respectively. 53% of the 285 sub-counties (districts) in 2014 reported a pentavalent 3 coverage of <80%. Eleven percent of the sub-counties reported pentavalent3 coverage of <50%. The lowest wealth quintile and households with mothers with no education report poorest coverage and highest dropout (KDHS 2014). Immunization coverage in the DHS was higher and indicated better routine immunization performance than administrative data.

Achievements

Vaccine Introduction Grant (VIG) for Rota enabled the country to undertake the following key routine immunization activities:

- Refresher training on routine immunization and multi-dose vial policy
- Supervision to lower health facility by national and district EPI team
- Community mobilization to promote routine immunization
- Promotion of other diarrheal prevention interventions
- Printing of routine data collection tools including tools for managing vaccine stock levels
- Advocacy with key stakeholders at national and county level to mitigate negative effects of rumors on vaccine safety by elements within the catholic church
- Procurement of 42 cold chain equipment to increase number of health facilities providing immunization services

Challenges

- Delayed disbursement of Rotavirus VIG grant led to phased introduction of rotavirus depending on the ability of the counties to pre-finance vaccine introduction activities.
- Kenya experienced stock out of rotavirus vaccines for two weeks towards the end of 2014 at the health facility level. This was as a result of vaccination of children outside the recommended age i.e. pentavalent naive children and low forecasting due to previous age restriction. Further, buffer included in the vaccine supply was not adequate. This was resolved by requesting for supplementary doses from Gavi where 2015 doses were brought forward to 2014 and 2015 order was increased. The country has informed the county managers on appropriate age for administration of rotavirus vaccine and is in the process of reviewing the immunization card and policy.
- Poor performance of the Rotavirus vaccine coverage has been noted mainly due to low reporting, application of age restriction even after its removal since some reporting tools (Mother child Cards) still had the age restriction. A policy statement has since been shared to correct this. HR challenges-strikes may have contributed to low performance
- Reduced funding for the immunization program nationally and county level due to the devolution of funds to the county Governments
- Delays in securing funds for procurement of new and routine vaccines
- Weak supply chain management at the sub county level due to inadequate knowledge and skills of newly employed managers and health workers. Discrepancies between paper-based stock ledgers and web-based SMT at national and regional stores primarily due to internet connectivity issues.
- Visibility of Vaccine stocks utilization at the sub county store level is lacking and facility level data is of poor quality
- Data challenge with discrepancy between the administrative coverage and coverage from surveys carried out routines. The administrative coverage is lower than survey coverages which point to issues with denominator
- Cold chain capacity challenges at some district and facility level with the introduction of Rotavirus vaccine. This is currently managed through frequent pickups

- The SARAM (Service Availability and Readiness Assessment Mapping) identified that only 62% of facilities were capable of providing quality immunization services. There were human resource challenges in several counties; facilities are not adequately staffed and weak capacity of several managers to manage immunization services due to movement/reshuffling of the managers across health programmes.
- Security challenges especially in northern Kenya are leading to closure of health facilities in affected areas.
- Emerging vaccination hesitancy creating a negative effect on building community trust
- Inadequate funding for implementing social mobilization and communication activities
- Lack of clarity of roles and responsibilities of the national government vis a vis county government in regard to immunization support

Key recommended actions to achieve sustained coverage and equity (list the most important 3-5 actions)

- Increase immunization performance by reducing inequities across and within counties by scale up of reach every child/community (REC)
- Improve governance at all levels, coordination between national and county government and mobilize resources for immunization at national and county levels:
- Strengthen the County and Sub-county Capacity to deliver vaccines including better planning, budgeting and maintenance of an efficient vaccine supply, logistics and cold chain system
- Strengthen immunization data collection, reporting, monitoring processes and use of information at all levels
- Generate demand for vaccines and improve visibility of immunization among communities including risk communication

1.3. Requests to Gavi's High Level Review Panel

Grant Renewals

New and underused vaccine support

The country requests renewal of support for the following vaccines through 2017:

- Renewal of New vaccine support for Pentavalent vaccine
- Renewal of New vaccine support for Pneumococcal vaccine
- Renewal of New vaccine support for Yellow Fever vaccine
- Renewal of New vaccine support for Rotavirus vaccine
- A new HPV demo application submitted in September 2015 for review by IRC in November 2015

Health systems strengthening support

- Application for Gavi HSS funding was not approved in 2015. New application will be submitted in January 2016.

1.4. Brief description of joint appraisal process

[More details can be provided in an Annex]

- The joint appraisal was initiated by the Ministry of Health and involved key partners and stakeholders in collating the evidence and writing of the report. Prior to the appraisal, the partners held several meetings to draft the initial report that was shared with Gavi team and formed the working document during the appraisal.

- The in-country team included the Ministry of Health and local partners who included: UNICEF- KCO, WHO-KCO, USAID, USAID-MCSP, JSI, CRS, CHAI, KANCO, HENNET, UNICEF-ESARO and WHO-AFRO.
- The Joint Appraisal took place during the week of 24th - 28th August 2015. The Joint Appraisal team from Gavi deliberated on the draft report, with in-country team providing clarification and further insight when required. New suggestions to the report were made and the report writing team tasked with finalizing the report
- The process involved an introductory meeting by Gavi to the Child health ICC and MoH followed through by having several team meetings, reviewing data and analyzing reports for to be included in the meeting. The GoK and partners constituting the JA team then wrote different sections of the plan; these were collated, reviewed and shared with partners for comments.
- The report was shared with the Child-Health ICC on 8th September 2015.

2. COUNTRY CONTEXT

(MAXIMUM 1-2 PAGES)

2.1. Comment on the key contextual factors that directly affect the performance of Gavi grants.

[See guidance document for more details]
Overall health system

Devolution of health services

Kenya enacted a new constitution in 2010 that is considered as one of the most progressive and rights-based in the world today as its bill of rights, for the first time, recognizes social and economic rights such as health, education, water, food, social security, among others. It also places great emphasis on the marginalized and disadvantaged groups such as women, youth, children and the disabled. The constitution also devolved political power and governance to two levels of government, National and 47 newly created and semi-independent counties which have clearly defined functions. County assemblies consisting of 1,450 elected representatives (ward representatives) provide oversight over county executive led by an elected Governor. Following 2013 national elections and as part of the process of implementing the new constitution, the newly elected government rapidly devolved health services including Human resources Management to the 47 counties. The counties receive budgetary allocation from national treasury through clearly defined revenue allocation criteria, to implement county specific integrated plans after approval by the county assembly. While health is the major devolved function, the national government has no direct control on how much is allocated to health sector at county level. Due to the haste in devolving health, it has taken time to establish intergovernmental coordination mechanisms and there is still lack of clarity on the roles and responsibilities across the two levels of government which is affecting adequate financing for health services at county level and decline in technical support by national programs.

The national government is responsible for service delivery at 4 tier six hospitals (national referral and teaching hospitals); procurement of vaccines including Gavi supported vaccines, distribution of vaccines to the 9 regional vaccine stores; policy development; research; advocacy; resource mobilization; capacity building of County staff; oversight on quality and standards and management of the health information system. Immunization service provision is guided by national vaccination policy. The Ministry of Health (MOH) is working to support the county Governments in the implementation of service provision related to immunization but this is proving to be a challenge due to reduced funding to the National immunization program.

Each County government is responsible for service provision in all the 5874 health facilities providing immunization services, procurement and distribution of cold chain equipment, injection and injection safety devices to health facilities; printing of data collection and reporting

tools; communication and social mobilization; resource mobilization; support supervision and reporting of data at the county level.

While Kenya continues to experience challenges linked to devolution of health services, there has been notable increased investment in expanding access in regions that have previously suffered many years of underdevelopment. In these regions, the county governments are employing additional technical staff, building new health facilities and supporting outreach and mobile services. This is expected to improve health outcomes in the coming years. Devolution has also provided opportunity for communities to define their needs and participate in planning and budget allocation as defined in the constitution. There is however need to continue addressing challenges linked to management of human resources, linkages across counties and with national government and coordination of stakeholders.

Human resources capacity

Kenya spends fifty five percent of public health expenditures (Government and Donors) on human resources. The optimum staffing is defined for each health facility, based on its actual workload.

As provided by the 2010 Kenya constitution, health services were devolved in 2013 and hence management of health workforce became one of the functions of the County government. Consequently, new managers and health care providers were appointed/deployed/recruited to provide health services. Health workers were seconded by the National government to County Government for a transitional period of 3 years. Devolution resulted in close supervision and better accountability of health workers. However, delays in payment of salaries and the lack of clear system for staff promotions and motivation has resulted to low staff morale with resultant resignation of staff and frequent strikes of health worker negatively affecting service delivery. Devolution of health services places additional management responsibilities to health managers at County and sub-county levels especially in program management, advocacy, resources mobilization and leadership. This calls for the need to strengthen the capacity of staff in management, leadership and all work streams of immunization, at decentralized level. While the national government with support from partners continue to orient tutors in training institution to improve the competencies of pre-service medical and nursing students, financial constraint has limited training of in-service healthcare providers. Currently less than 1% of frontline health workers receive EPI updates in any given year.

There are currently 25,000 community health volunteers in the country who are involved in immunization related activities such as defaulter tracing and social mobilization. However there is a need for building their capacity on EPI specific areas, including provision of job aids.

Data management, monitoring and evaluation

Kenya has a National reporting system for the Ministry of Health where immunization data is reported among other health indices. There is an electronic data management system “District Health Information System” (DHIS) which is managed by the Unit of Health Information Systems within the Ministry of Health. Health facilities generate immunization data which is transmitted monthly to the sub-county where data is aggregated and subsequently transmitted to the County level. Data is entered electronically at the County level and that data is available in a central server hosted by the national Ministry of Health unit of Health Information System. The DHIS has data on routine immunization coverages and vaccine stock levels. The County governments are responsible for the generation of county relevant reports, printing of county tools and entry of the data into the DHIS. The country utilizes surveys and studies including Kenya demographic and health surveys (KDHS) to generate additional information to inform decision making. The last DHS was conducted in 2014 and Key Indicators Report is available. Following devolution of health services, reporting rates (timeliness and completeness of

reports) declined due to lack of reporting tools in most health facilities and support for data quality audits by counties.

The 2014 KDHS results showed lower immunization coverage and higher dropout in children's whose mothers were not educated compared to the administrative coverage Children born in households from the lowest wealth quintile also had poor performance. The discrepancy between routinely collected administrative data and surveys may be as a result of under-reporting and higher denominator than the actual. Routine and survey data are analysed at national level and shared with immunization partners and counties. This practice is however rarely done at county level due to insufficient financial and technical supports. There is need to improve data availability, quality and use for decision making at decentralized levels.

Vaccine supply chain and cold chain management

The Kenya vaccine cold chain is made of 1 central vaccine store located in Kitengela, which is the primary depot. Below this level are 9 regional stores in Nairobi, Mombasa, Kisumu, Nakuru, Eldoret, Garissa, Meru, Kakamega and Nyeri. These regional stores are the hubs that hold vaccines for the sub county stores. There are 290 sub county vaccine stores which serve over 5600 facilities. The National Government is responsible for managing the National and regional vaccines stores while the subcounty vaccine supply chain is managed by the county governments. Other commodities such as syringes, sharps disposal boxes and dry goods are distributed by the Kenya Medical Supply Agency (KEMSA) and the Unit of Vaccine and Immunization Services (UVIS) while some are procured and distributed directed by county management. KEMSA distributes goods and services directly to facilities through their distribution system while (UVIS) distributes to the regional store for pick-up by the sub county stores. With this current arrangement, bundling of vaccines and injection devices is not done. KEMSA regional depots do not have sufficient capacity to store immunization syringes, hence these are distributed directly to sub county vaccine stores at least twice a year. This coupled with inadequate supply of the same results in shortages at Service Delivery Points. The national store and three regional depots benefitted from the JICA project and have ample dry storage space, but HR capacity to manage the warehouses is lacking, hence the continued dependence on KEMSA. The Ministry of Health outsources clearing and distribution of vaccines and related items from the national store up to regional store and this has improved the stock availability, clearance and management of supply chain at the national and regional store level.

The programme carries out a vaccine forecasting exercise every year, in conjunction with UNICEF who is in charge of vaccine procurement, and other partners. Both the WHO and UNICEF logistics forecasting tools are applied. Representatives from county level as well as input from county specific immunization performance are involved to increase accuracy of the forecast.

Availability and use of stock management tools, both paper and electronic based, are limited at county level. Consequently vaccine utilization is not monitored systematically at all levels. Challenges with internet connectivity and general IT support have also greatly affected the quality of stock management data at national and regional storage points, resulting in huge discrepancies between the two systems. Currently UNICEF and CHAI are supporting MoH to better monitor vaccine utilization by rolling down the electronic SMT up to sub-county stores, printing of tools, enhancing the capacity of staff at regional and county level as well as supporting the government to implement 2013 EVMA recommendations.

The EVM, among other challenges showed inadequacies in: 1) vaccine clearance; 2) temperature monitoring; 3) storage capacity at sub-county stores; 4) stock management and distribution at lower levels; 5) Wastage rates tracking; and 6) Support supervision and skills of managers and caregivers.

With support from KFW/UNICEF/CHAI, the Unit procured cold chain equipment which has enabled the country ensure adequate cold chain capacity in 290 sub-county (then district) stores, equip several HFs with refrigerators for expansion of immunization services and rollout of continuous temperature monitoring devices in all immunizing health facilities. Distribution of some of the equipment is still ongoing with support from UNICEF as well as repair of broken down equipment. The unit also plans to improve cold chain efficiency by replacing all absorption and gas powered equipment with Solar Direct Drives where electricity is not available. To achieve this, the Unit needs to mobilize financial support to procure 1041 solar direct drive cold chain equipment for replacement and expansion. Currently, 50% of the country has no access to electricity. . In addition, 90 new health facilities with electricity lack cold chain equipment while 1336 require replacement.

There are several challenges with the current vaccine supply chain and cold chain mainly due to the lack of clarity on the roles and responsibilities of the different Governments, agencies and departments. There is currently a Health Bill in parliament that will define the roles and responsibilities of the different levels of Government.

Funding of Immunization services

The Government of Kenya funds procurement of all the traditional vaccines (including storage and distribution) and co-finances with Gavi for the new vaccines (Penta, PCV, YF, Rota). Following devolution of health services to the counties, in FY 2013/14 funds for procurement of vaccines were fully devolved to counties which did not yet have capacity for vaccines procurement. This resulted in the country defaulting for Gavi co-financing in 2014. The country also delayed in meeting MOH/UNICEF VII (Vaccine Independent Initiative) agreement. Annual Work Plans developed by most county teams are not adequately funded due to diminished prioritization of immunization by county governments. Decision has now been made by intergovernmental budget and economic council to have all procurement of vaccines at national level.

Below table summarizes Government and Gavi contribution for immunization programme in the last four years.

UVIS budget (historic and projected) by categories and FYs (in USD)

	FY2012/2013	FY2013/2014	FY2014/2015	FY2015/2016
National Budget (GOK)				
Traditional infant vaccines	2,395,610	-	-	2,903,754
Other vaccines (Non EPI)	-	1,497,860	145,517	2,323,003
GAVI Co-financing	4,615,869	3,018,942	3,026,762	3,484,505
Operations and maintenance	1,110,964	-	38,064	1,161,502
Total GOK	8,122,444	4,516,802	3,210,343	9,872,765
Gavi Grant	65,511,961	30,189,423	30,267,624	39,723,360

Source: MoH 2013, using exchange rate of 1USD = 86.1 Kes

Funds for co-financing of Gavi NVS in 2013 calendar year were allocated in the national budget for 2013/14 FY ($3 million). Co-financing funds for 2013 were transferred to UNICEF account in time. However no funds were allocated to traditional vaccines for FY 2013/2014 and vaccines stocks had been depleting. UVIS/MoH decided to use a portion of co-financing funds sitting on UNICEF's account for the procurement of traditional vaccines to avoid traditional vaccine stock out at the national level in 2013. Outstanding co-financing amounts (for 2013) were transferred to UNICEF in the first half of 2014, however Gavi qualified Kenya to default for 2013 co-financing because the full amount was not paid in time. Funds for traditional vaccines had not been appropriated in 2014/2015 budget as well and according to UVIS estimates, 370 million KSHs ($4.2 million) are needed to meet the country's needs in traditional vaccines and avoid

stock out at the national level in December 2014. No Operational and maintenance funds were appropriated in 2013/14 and 2014/15 FYs that are critical for customs clearance at the border, transportation and storage at national and regional warehouses.

It has to be noted that Gavi's financing cycles are not aligned with the Government of Kenya's planning and Financial years. The mismatch in the two financing cycles affects the promptness of GoK clearing her co-financing obligation. To address future delays in co-financing, a proposal was made to Gavi by the joint appraisal team to consider sharing with the GoK a two year decision letter covering up to 2017. It is envisioned that this will enable the country secure funds in time in spite of difference in financial years between Gavi and GoK.

Management and Governance of the Immunization services

The Immunization services in Kenya are managed by the Ministry of Health through the Unit of Vaccines and Immunization Services (UVIS) and the Disease Surveillance and Response Unit (DSRU). UVIS manages the routine immunization while DSRU manages vaccine preventable diseases surveillance and outbreak response. The two units report through their respective divisional heads to the Director of Medical services.

Several partners support the Ministry of Health through program specific technical working groups (e.g. Immunization, Child Health, and Reproductive Health) and the Child Health Interagency Coordinating committee (CH-ICC). The CH-ICC provides a forum for coordination of investments in child and adolescent health, supports management of key action points and oversees the work of appointed technical working groups and taskforces. It comprises of MoH, development partners, Health NGOs Network (HENNET) and Faith Based Organizations. It is chaired by the MoH and meets quarterly with provision for special meetings if necessary.

Immunization technical working group is led by the EPI manager and is accountable to the CH-ICC. The ICC is a platform for interagency coordination, resource mobilization, and policy guidance. The CH-ICC also receives technical inputs from technical working groups that are set up with authority and approval by the ICC for particular topics and areas such as new vaccine introductions, proposals and applications, and campaigns.

ICC reports to the health sector coordinating committee (HSCC), chaired by the Principal Secretary for Health, which supervises the health sector in general. The HSCC has however not met since 2013 when the government functions were reorganized.

In 2014, Kenya National Immunization Technical Advisory Group (KENITAG) was established to provide independent technical guidance on immunization to the Ministry of health.

In 2013 when the devolved system of government came in to force, health management functions including immunization were decentralized with funds being managed by the devolved units (Counties). At national level, the health is head by a cabinet secretary while the accounting officer is the principal secretary both not being elected officials. At the county level, their equivalents are the County Executive Committee Member (CEC) and Chief Officer respectively. Below this level, each county is at liberty to have a structure that suits the county.

The Counties are responsible for delivery of immunization services including procurement of relevant tools and equipment while the national government is responsible for procurement of vaccines and development of policy, guidelines and standards as well as management of central and regional vaccine stores. Though the national government may not supervise the county governments, it may provide guidance through consultation and continuous collaboration with the devolved units.

Demand Generation and CSO involvement

The Advocacy Communication and Social Mobilization (ACSM) sub-committee within the MoH is responsible for coordinating and providing technical support on social mobilization and communication activities related to EPI. All sub-counties have health promotion officers who are responsible for social mobilization and communication. Less than 10% of sub-counties have functional ACSM sub-committees and communication plans of actions.

Previously, Kenya has faced challenges from certain quarters in regards to immunization and specifically conducting tetanus SIA in high risk districts and recently OPV SIAs, alleging vaccine contamination. The ACSM committee played a key role in demystifying the rumours created recently by the catholic church leadership. As a means to prevent future derailment, ACSM activities have been integrated within all immunization activities to enhance citizen awareness.

In Kenya, Community Health Volunteers (CHVs) and village leaders are the frontline workers for social mobilization. However communication has received limited attention by the EPI program due to funding constraints. In addition, ACSM has previously been handled as a single entity rather than an integral part to all the immunization activities during routine immunization and SIAs. ACSM has not leveraged on other existing avenues such as the utilization of the digital platforms such as Facebook, Twitter, and LinkedIn among others which have in the recent past been used widely by other entities, to disseminate information in Kenya. The MOH ACSM sub committee must also actively bring on board CSOs working at national, county and sub county levels in carrying out social mobilization and awareness creation to the community, since CSOs have a closer contact with the communities. Engagement of the private sector through the public private partnerships would support demand creation efforts. These strategies have not been exploited.

While evidence shows that around 94% of care givers appreciate the benefits of immunization which has contributed to less vaccine resistance, there is a limited knowledge of diseases prevented by the vaccines and the need to complete immunization schedule.

Community engagement and involvement needs to be strengthened to improve demand for and utilization of existing EPI services. The school health strategy of mobilizing children to reach families with key messages and for defaulter tracing during campaigns has been successful and needs to be scaled up also for routine immunization.

Mobilization of polio survivors as ambassadors for immunization is another success story which needs to be documented and scaled up. Ambassadors played a key role in addressing rumors on safety of polio and TT vaccines. The country needs to strengthen the risk communication plan and capacity to address rumors related to immunization. Linking community with services need to be strengthened through community participation and engagement with health professionals. Mobilizing polio network to strengthen routine immunization programme is already being done but needs strengthening.

Health NGOs Network (HENNET) is a coordinating platform for Health CSOs in Kenya and has a membership across all counties In Kenya. The platform is represented in the immunization working group. CSOs play an important role in mobilizing effective demand for services, building awareness of community needs, experimenting innovative approaches to service delivery and contributing to health systems strengthening at community level. The platform plays a key role in offering various capacity building at governance and community level as well as carrying out advocacy within this levels so as to create a rights based approach to vaccination. They work with all levels of Government and have a strong presence at the county level. There is need to leverage on past experiences and strengths of CSOs at county level to achieve immunization objectives, especially due to the integral roles a number of FBOs who operate health facilities do in offering immunization services in the hard to reach areas and

marginalized populations. The declining funding resources has posed a challenged towards continued service delivery by CSOs on immunization issues.

3. GRANT PERFORMANCE, CHALLENGES AND RENEWAL REQUESTS

(MAXIMUM 3-5 PAGES)

3.1 New and underused vaccine support:

3.1.1 Grant performance and challenges

Coverage

Immunization programme in Kenya provides 7 vaccine formulations through routine immunization programme. With support from Gavi, Kenya introduced Pentavalent vaccine in 2002, PCV 10 in 2011, Rotavirus vaccine in July 2014 and Yellow fever vaccine in 4 districts since 2002. In 2014, 1,579,365 children were born, of whom 1,466,308 survived. According to JRF, 81% received three doses of Penta vaccine, 80% PCV10, 40% Rota and 40% YF. It is important to note the YF coverage in APR is so low (1%) because the denominator applied is the national target population yet the vaccine is administered only in 4 districts. A 2 year HPV vaccine demonstration project conducted in one county between 2013 and early 2015 achieved coverage of 96 and 86 percent in the first and second year respectively.

Low coverage of rotavirus was as result of phased introduction of rotavirus vaccine in the last half of 2014. Some counties introduced rotavirus vaccine as late as October 2014. The performance reflects a dropout rate of 5.8% at national level with 8 counties reporting more than 10% dropout rate between Penta1 and Penta3. More than half (53%) of sub-counties (districts) report coverages below 80% for penta3. Measles second dose was introduced into Kenya's routine immunization programme and coverage has been low at 15% in 2014.

Equity

Variations exist in the coverage levels among different counties. 53% of the 285 sub-counties (districts) in 2014 reported a pentavalent 3 coverage of <80%. Eleven percent of the sub-counties reported pentavalent3 coverage of <50%. Some counties in densely populated areas especially in urban dwellings contribute a significant proportion of the large number of unvaccinated children. Low coverages has been reported in insecure areas e.g. Pentavalent 3 coverage in Mandera county is 49%. The lowest wealth quintile has poorest coverage and highest dropout. Mothers with no education had the poorest coverage compared with educated parents. The lowest wealth quintile however has a better coverage performance compared to no education mothers. (KDHS 2014)

At national level, there is no difference in immunization coverage based on sex. The picture at subnational level may however be different and there is need to validate these assumptions with surveys such as the DHS 2014. There are no social, cultural and economic factors that discriminate either gender in immunization services. Children in Rural areas and in households where mother has no education are however less likely to be vaccinated compared to children from urban and educated households.

Grant Utilization

Vaccine Introduction Grant (VIG) for Rota enable the country to undertake the following key routine immunization activities:

- Refresher training on routine immunization and multi-dose vial policy
- Supervision to lower health facility by national and district EPI team
- Community mobilization to promote routine immunization
- Promotion of other diarrheal prevention interventions
- Printing of data collection tools

The table below summarizes amount of new and underutilized vaccines received in 2014

Vaccine type	Total doses for 2014 in Decision Letter	Total doses received by 31 December 2014	Total doses postponed from previous years and received in 2014	Did the country experience any stockouts at any level in 2014?

Pneumococcal (PCV10)	4,381,300	4,152,200	122,000	No
DTP-HepB-Hib	2,527,100	2,033,600	775,000	No
Rotavirus	1,498,500	2,143,500	0	Yes
Yellow Fever	52,800	27,600	12,500	No

Kenya is currently conducting feasibility study on use of mixed vial presentation of pentavalent vaccine with results expected to inform decision making on the use of multiple presentations of pentavalent vaccine to help reduce wastage rate and optimal utilization of cold chain.

Kenya runs sentinel surveillance of rotavirus and invasive pediatric bacterial disease (IBD). In 2014, 25% of <5year old children with diarrhea with suspected gastroenteritis tested positive for rotavirus by ELISA. Intussusception studies are carried out in 6 surveillance sites. Preliminary findings of July–December 2014 reports 44 cases of intussusception out which 6 died.

The Rotavirus PIE was done in May 2015 with the recommendations informing review of the cMYP. Some of the key recommendations include:

- Development and dissemination of guidelines for planning and budgeting for operational activities at county level
- Development of specific communication strategies to increase demand for immunization especially in the second year of life
- National to work with county health management teams to develop a capacity building plan as part of immunization system strengthening, and provide training for county health managers in resource mobilization, programme management skills etc
- Urgent measures to be taken to address vaccine stockouts reported at the time reporting and other related supplies
- National level to allocate adequate human and financial resources for proper management of regional vaccine depots
- Develop AEFI management protocol and reporting tools, and review the immunization policy guide to accommodate recent developments in immunization and comply with global and regional standards

Challenges

- Delayed disbursement of VIG grant led to phased introduction of rotavirus depending on the ability of the counties to pre-finance vaccine introduction activities.
- Kenya experienced stock out of rotavirus vaccines for two weeks towards the end of 2014 at the health facility level. This was as a result of vaccination of children outside the recommended age i.e. pentavalent naive children and low forecasting due to previous age restriction. Further, no buffer was included in the vaccine supply. This was resolved by requesting for supplementary doses from Gavi where some 2015 vaccines were brought forward to 2014. Provision for buffer stock was made by adding doses allocated for 2015. The country has informed the county managers on appropriate age for administration of rotavirus vaccine and is in the process of reviewing the immunization card and policy to reflect the same.
- Poor performance of the Rotavirus vaccine coverage has been noted mainly due to reporting following removal of age restriction while reporting tools (Mother child Cards) still had the age restriction. HR challenges-strikes may have contributed to low performance.

3.1.2 NVS renewal request / Future plans and priorities

NVS renewal request:

- The country requests an extension of Gavi support for the years 2016 to 2017 for the following vaccines without a change in vaccine presentation

    - Renewal of New vaccine support for Pentavalent vaccine
    - Renewal of New vaccine support for Pneumococcal
    - Renewal of New vaccine support for Yellow Fever vaccine
    - Renewal of New vaccine support for Rotavirus vaccine
    - Renewal of New vaccine support for Inactivated Polio vaccine

Future plans:

- The country submitted a new application for HPV demo project in September 2015 to start in 2016 targeting girls 9-10 years old
- HPV scale up in 2017
- MR Introduction in 2017. The country also applied and received support for a campaign for the Measles Rubella vaccine campaign which will be conducted in January 2016 after which the vaccine will be introduced into the routine system in 2017.
- Equity analysis at subnational level
- The country will also be applying of HSS grant in the financial year 2015/2016

3.2. Health systems strengthening (HSS) support:

Kenya applied for Gavi HSS grant in 2014 which went through two sets of IRC feedback and revisions between June 2014 and Jan 2015. Comments Review Panel met in April 2015 and declared the HSS proposal to be unsuccessful for the following reasons:

- Of the 8 comments originally provided by the IRC, the majority are still incomplete and insufficient.
- In the process of responding to the IRC's comments, modifications have been made to the budget, work plan and narrative of the proposal that are substantial and material, and are only partly justified by the IRC comments.
- Through the several resubmission and modifications, the proposal has lost coherence which risks a lack of clarify when it comes to implementing the activities
- The country was has however later asked to reapply in 2015. The government is committed to resubmitting in January 2016 and will need technical support from Gavi alliance partners (WHO and UNICEF) to achieve this**.**

New application will be submitted in 2016 with a total budget of USD 39.1 million and a total amount to be budgeted of USD 32.84M (performance based financing method applied in Years 2-5).

HSS workshop will be conducted on 21st to 23rd October 2015 and GoK request for WHO/UNICEF TA (both for consultant and workshop) has been shared.

3.2.1. Grant performance and challenges

Kenya currently has no HSS grant and will be applying for the HSS grant in the financial year 2015/2016

3.2.2. Strategic focus of HSS grant

Kenya applied for the HSS grant which was approved by IRC but later denied in 2015 by GAVI comments review panel (CRP). Kenya will re-apply for a HSS grant in the financial year 2015/2016. The overall goal of the HSS proposal will be to Improve and sustain national immunization outcomes by strengthening the devolved health system and focus on equity.

3.2.3. Request for a new tranche, no-cost extension, re-allocation or reprogramming of HSS funding / Future HSS application plans

Kenya currently has no HSS grant and will be applying for the HSS grant in the financial year 2015/2016

3.3. Graduation plan implementation *(if relevant)*

Kenya will be entering the "preparatory transition phase" from 2016. This was discussed during the JA meeting. Gavi's co-finance plan where the country will be expected to pay $US 4.5million for co-financed vaccines by 2020 is agreeable but there is need of advocacy meeting and technical assistance to the country to ensure graduation plans are developed and implemented successfully.

3.4. Financial management of all cash grants:

[Comment on all bolded areas listed in the table in this section of the guidance document]

By end of 2014, Kenya had cumulatively received a total of USD 17,157,143 cash support (HSS, INS, ISS, HPV, VIG). USD 1,218,500 was received in 2014 for Rotavirus vaccine introduction and USD 145,000 for HPV demo in 2013 through UNICEF. Part of the HPV grant amounting to USD 70,250 was carried forward from 2013 and spent in 2014 and 2015 for the project. The entire HPV introduction grant has been utilized for the HPV launch. Financial reports on both VIGs have been sent to Gavi by UNICEF. A balance of USD 144,473 of the Rota VIG is being utilized to mobilize communities to increase coverage and print additional reporting tools.

Kenya has outstanding audit issues relating to previous HSS and ISS support. The Gavi Audit team visited the country from 31st august 2015 to 4th September 2015 for the purpose of making preliminary assessments of both GAVI HSS and ISS funding so as to prepare ground for the audit of both funds. The team met a number of officers both from the Government and Health partners including the principal secretary Ministry of Health. The team is expected to advise the country of their next visit to commence the audit. It is anticipated that this process will be completed by end of October 2015**.**

3.2. Recommended actions

Actions	**Responsibility** (government, WHO, UNICEF, civil society organizations, other partners, Gavi Secretariat)	**Timeline**	**Potential financial resources needed and source(s) of funding**
1. Improve governance and coordination at all levels: • Clearly define immunization roles and responsibilities at the national and county level. • Establish a coordination mechanism for immunization between national and county Governments •	Government	Q1 2016	Gavi, UNICEF
2. Mobilization of financial resources for immunization at national and county levels: • Develop national and county levels costed multi-year and operation plans • Develop advocacy tools and video for prioritization of immunization programmes • High level advocacy to leadership (national and county) and private sector • Multi-sectoral engagement • National and county government to map and leverage on non-immunization resources/programmes to support immunization (Global fund, GFFHIV, Malaria etc…) • Develop financial sustainability plan at the county level • Develop proposal for funding using Gavi HSS funding platform •	Government, UNICEF, WHO, USAID-MCSP,JSI, CSOs	Q1,Q2, Q3, Q4 2016	Gavi, UNICEF, USAID

3. County and Sub-county Capacity Strengthening : • Build capacity of county managers, on leadership, programme management, procurement, resource mobilization , advocacy and financial management • Conduct operational level training for sub-county immunization managers and health workers in poor performing areas • Orient CSOs on immunization	Government, UNICEF,WHO, USAID-MCSP(in Migori and Kisumu),JSI	Q2-Q4 2016	Gavi
4. Reduce inequities in immunization coverage across and within counties: • Identify low performing counties and develop county specific immunization improvement plans • Roll out reach Every Child Strategy in targeted counties • Conduct immunization equity analysis • Identify strategies to improve MCV2 coverage (vaccination uptake in the second year of life)	Government, WHO, USAID-MCSP (in Migori and Kisumu),JSI, UNICEF	Q4 2015	WHO, CDC, USAID, UNICEF
5. Strengthen immunization data collection, reporting, monitoring processes and use of information at all levels: • Review, finalize and implement data quality improvement plan • Develop M&E framework for immunization programme • Regular engagement with county immunization managers to review immunization and vaccine stock data to identify and address issues that contribute to poor data quality • Address Immunization data flow challenges from the health facility, to county and to the national level • Support immunization financing expenditure data tracking, use and reporting	Government, WHO UNICEF, USAID-MCSP(Migori and Kisumu),JSI, CHAI	Q1-Q4 2016	Gavi, Immunization Partners

6. Generate demand for vaccines and improve visibility of immunization among communities • Develop County specific social mobilization and communication plans • Develop and implement Risk communication plan	Government, UNICEF,JSI	Q1,2 2016	UNICEF,JSI
7. Improve and maintain efficient Vaccines supply and cold chain: • Finalize and operationalize Cold chain replacement and maintenance plan. • Roll out of the stock management tool to sub-counties • Update and implement vaccine management guidelines • Improve vaccine wastage monitoring	Government, UNICEF, CHAI, WHO, USAID-MCSP(Migori and Kisumu),JSI	Q1,2 2016	Gavi, UNICEF, CHAI,USAID
8. Evidence generation, surveillance and new vaccine introduction: • Evidence generation to demonstrate burden of disease and impact of vaccines in Kenya • Strengthen vaccine preventable diseases (VPD) surveillance and laboratory • Operational research on priority issues affecting immunization programme • Document challenges and best practices/approaches used to reach unimmunized children in Kenya • Planning for introduction of new vaccines (MR campaign and routine introduction, HPV demo and national introduction)	Government, WHO, UNICEF,JSI		Gavi, CDC

4. TECHNICAL ASSISTANCE

4.1 Current areas of activities and agency responsibilities

The program has received support from several partners in several areas of the immunization program.

Cold chain and temperature monitoring
The country has rolled out fridge tag 2 to all counties except 1 and is in the process of evaluating the impact of the fridge tag use at facility. The country has also performed a temperature mapping of the cold rooms at the national and regional cold room stores. The country has also been expanding the cold chain space through procurement of cold chain and spare parts with support from the KFW German development bank and UNICEF. The program is also in the process of finalizing its 5 year cold chain replacement and expansion plan.
The Government has received support from several partners in the area of cold chain and temperature monitoring and they include JICA, UNICEF, KFW German Development Bank, CHAI, WHO and MCSP.
Planning program management and coordination
The country is currently in the process of updating the comprehensive multiyear plan and supporting counties come up with county specific plans. The aim of the plans is to ensure appropriate interventions are being utilized by the country nationally and by counties and to plan and track progress of the immunization program.
The country is also planning to develop a new HSS application based on the national CMYP and county level plans.
UVIS is supported in this workstream by UNICEF, WHO, KANCO, MCSP-USAID, JSI, CHAI and HENNET.

Advocacy and social mobilization
The country is having advocacy and stakeholder meetings between the counties and the national level staff. The aim of the advocacy and stakeholder meetings is to improve communication between the 2 levels and to advocate for funding allocation by both levels of Government.
UVIS receives TA in this work stream mainly from UNICEF and other partners including HENNET, KANCO, the Latter Day Saints foundation and MCSP-USAID.

Data Quality and review
Data quality reviews and data quality analysis is carried out on routine data to ensure that the quality of the data is similar. The unit is supported in this work stream by WHO, CHAI, UNICEF and MCSP-USAID.

Surveillance and Disease control
The unit has been receiving technical support in setting up surveillance sites for example Rota surveillance site, managing polio and tetanus campaigns, and managing the polio end game strategy.
Support for this work stream is mainly WHO and UNICEF. Other major players include the CDC, MCSP-USAID and KEMRI.
In general there are several partners supporting different areas of the immunization system at different levels and counties governments receive technical assistance from some of the partners listed here as well as other partners who operate at the county and sub county level. The list above is not meant to be comprehensive.

4.2 Future needs

Disparity analysis:

- Ask UNICEF and WB to conduct vulnerability assessment relevant to immunization
- Identification of counties with large number of unimmunized children
- Priority areas to address inequity and disparity
- Development of Equity Improvement Plan

Vaccine supply chains

- Resources in finalization and implementation of cold chain replacement expansion and maintenance plan (REM)
- Strengthen Stock management at sub-county level- rollout of SMT
- Cold chain technician training on maintenance and repair of CCE.

Planning program management and coordination

- Financial and Technical assistance in improving capacity of managers (county and national) in
  - Resource mobilization,
  - development of immunization improvement plans
  - Reviewing Roles and Responsibilities for National and county program managers in context of devolution
  - advocacy
- Development of M&E plan
- Technical assistance in developing and implementing microplans as part of RED/REC approach in selected counties/villages/undeserved areas due to security or remote issues
- M&E TA
- Review cMYP

Advocacy and social mobilization

- Development of C4D plan for deprived areas
- Technical assistance in developing an advocacy toolkit
- Capacity building in planning, implementing, supervising ad monitoring social mobilization and communication.
- Communications TA

Data Quality and review

- Technical assistance in developing and implementing data quality audits.
- Financial assistance to scale up of MCH/Birth registration strategy

5. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT& ADDITIONAL COMMENTS *(MAX. 1 PAGE)*

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism: The ICC was given a de-brief of the joint appraisal process on 8th September, 2015. Prior to this meeting the Joint appraisal draft report was shared with the members for comments. Inputs and comments raised during the meeting were noted and incorporated into the final report. ICC members' signatures were obtained after the report had been edited and circulated to again.
Issues raised during debrief of joint appraisal findings to national coordination mechanism:
Any additional comments from • Ministry of Health: • Partners: • Gavi Senior Country Manager:

6. ANNEXES

[Please include the following Annexes when submitting the report, and any others as necessary]

- **Annex A. Key data** (this will be provided by the Gavi Secretariat):
- **Annex B. Status of implementation of the key actions from the last joint appraisal and any additional High Level Review Panel (HLRP) recommendations**

Key actions from the last appraisal or additional HLRP recommendations	Current status of implementation

- **Annex C. Description of joint appraisal process**

- The Appraisal team was composed of the following broad groups
    - Ministry of Health
    - National Treasury
    - In-Country Partners: UNICEF- KCO, WHO-KCO, USAID, USAID-MCSP, JSI, CRS, CHAI, KANCO, HENNET
    - Regional partners: UNICEF-ESARO and WHO-AFRO.
    - Gavi Team

Apart from Gavi and regional partners who support the EPI globally, the local partners were selected because they support various work streams namely;

- Supply chain Logistics and temperature monitoring – UNICEF, CHAI, WHO USAID-MCSP

- Planning, program management and coordination- UNICEF, WHO, KANCO, USAID-MCSP, CHAI, HENNET.
- Advocacy and social mobilization - WHO , UNICEF,USAID-MCSP, HENNET, KANCO
- Data quality and review: WHO, UNICEF , CHAI, USAID-MCSP
- Surveillance and disease control; WHO, UNICEF, USAID-MCSP

The process was initiated and coordinated by the ministry of health. Prior to the Ministry of Health organized meetings with the key partners at national level to draft the report. The in-country team reviewed performance data for 2014 as well as recent EVMA, PIE and EPI/surveillance reports. Data relevant to the appraisal was extracted from the reviews was included in the draft report. Different sections of the report were assigned to different partners for drafting. The draft report with then shared with all partners and Gavi team for further input and suggestions. Once all partners provided their inputs and comments, the draft became the working documents.

The Gavi team arrived in the country on 23rd August 2015 and the joint appraisal started on 24th August. The joint appraisal team discussed each section of the draft report checking the accuracy and clarifying comments. Specific questions were directed to relevant partners, depending on the type of support they provided to the Ministry of Health. In addition, the discussions provided further insights into what needs to be included in the report. The drafting team continued to refine the report during the appraisal to include new information requested and shared the same with the team.

After the five days of appraisal, a report writing team from MoH and local partner was formed and tasked with finalizing the report and presenting it to the Child Health ICC for approval. The reported was presented to the ICC on 8th September 2015.

- **Annex D. HSS grant overview:**

General information on the HSS grant							
1.1 HSS grant approval date							
1.2 Date of reprogramming approved by IRC, if any							
1.3 Total grant amount (US$)							
1.4 Grant duration							
1.5 Implementation year			month/year – month/year				
(US$ in million)	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
1.6 Grant approved as per Decision Letter	2,964,000	0	0	0	0	0	0
1.7 Disbursement of tranches (received funds)	2,089,500	0	0	0	0	0	0

1.8 Annual expenditure	2,844,164.80	2113762.90	240000	0	0	0	0
1.9 Delays in implementation (yes/no), with reasons			Delays in disbursements from National treasury to the ministry through the exchequer. This challenge addressed by the new Financial Management Act				
1.10 Previous HSS grants (duration and amount approved)							

1.11 List HSS grant objectives

(i) Building capacity for PME at implementation level

(ii) Monitor and follow up on performance monitoring in districts, using EPI as a probe

a. Supportive supervision to follow-up of capacity building in the districts with poor timelines and completeness of data
b. Development of quarterly summary of performance of district (data compilation and analysis)
c. Support to quarterly performance review meetings during AOP3, AOP4, and AOP5

(iii) Strengthening Governance in selected districts

a. Development of guidelines, and training manuals for Governance strengthening, particularly at implementation level
b. Training village, facility, and divisional Health Stakeholders Committee's on roles and functions in Governance in health
c. Training the facility staff on leadership and management as well as performance monitoring

1.12 Amount and scope of reprogramming (if relevant)

- **Annex E. Best practices (OPTIONAL)**

- **Anne F: Organogram of the Ministry of Health**