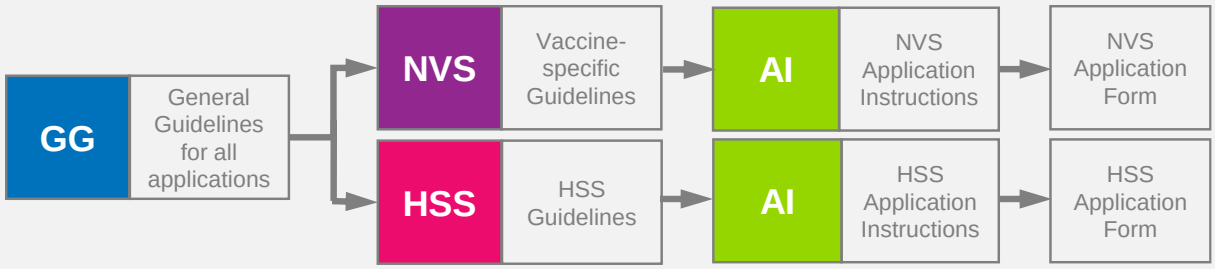
Application Form:
Health System Strengthening (HSS) Support in 2016

Deadlines for submission of application:
15 January 2016
1 May 2016
9 September 2016

Document dated: October 2015
(This document replaces all previous versions)

Application documents for 2016:

Countries applying for all types of Gavi support in 2016 are advised to refer to the following documents in the order presented below:



HSS Application Form

Purpose of this document:

This application form must be completed in order to apply for Gavi's HSS Support. Applicants are required to read the HSS Application Instructions prior to completing this application form and are advised to refer to these instructions whilst completing the application form. Applicants should first read the General Guidelines for all types of support as well as the HSS Guidelines before this document.

The application form, along with any attachments, must be submitted in English, French, Portuguese, Spanish, or Russian.

Web links and contact information:

All application documents are available on the Gavi Apply for Support webpage: www.gavi.org/support/apply. For any questions regarding the application guidelines please contact applications@gavi.org or your Gavi Senior Country Manager (SCM).

CONTENTS

PART A: SUMMARY OF SUPPORT REQUESTED AND APPLICANT INFORMATION

1. Applicant information		
Total funding requested from Gavi (US $)	*This should correspond exactly to the budget requested in Question 17 (detailed budget).*	
Does your country have a finalised and approved National Health Sector Plan?	Yes V	No ☐
	*Indicate the **end year** of the NHSP* ***Provide Mandatory Attachment #8: NHSP***	
Does your country have a finalised and approved comprehensive Multi-Year Plan (cMYP)?	Yes V	No ☐
	Indicate the end year of the cMYP *Provide **Mandatory Attachment #11**: cMYP* 2018/19	
Proposed HSS grant start date:	*Indicate the month and year of the planned start date of the grant*. July 2016	
Proposed HSS grant end date:	*Indicate the month and year of the planned end date of the grant.* June 2019	
Joint appraisal planning:	*Indicate when in the year the joint appraisal will be conducted, and which HLRP meeting the joint appraisal report will be submitted to.* HLRP in October 2016. The dates for the joint appraisal mission have not been agreed yet.	

2. Application development process *(Maximum 2 pages)*

Provide an overview of the collaborative and participatory application development process. Include the following ***Mandatory Attachments:***
#4*: Minutes of HSCC meeting, at which the HSS application was endorsed;*
#5*: Last 3 minutes of HSCC meetings; and*
#15*: TOR of HSCC*

The development of this proposal builds on lessons learnt from previous unsuccessful GAVI HSS grant applications. Building on the structures and process, consultations with key stakeholders were initiated by the Ministry of health in the last quarter of 2015. The Ministry of Health identified the causes of failures of the previous HSS.

The process of developing the current proposal involved the following national level departments, divisions, units and programs of Ministry of Health: Policy and planning, Health promotion, community health services unit, Disease Surveillance and Response Unit, Human nutrition and Dietetics unit, Health Information. The Unit of Vaccines and Immunization provided the stewardship. The County Governments department of health were engaged through various stakeholder meetings and working groups that were convened at different times to discuss the HSS proposal and challenges affecting the immunization program. County Directors of Health for Kajiado, Migori, Nakuru and Muranga Counties participated in the technical writing of this proposal

The Development Partners in Health, Kenya (DPHK) were regularly briefed. They reviewed the proposal and provided inputs that were considered by the drafting team. Members of the DPHK include: USAID, DFID, JICA, UNICEF, WHO, UNFPA, World Bank, IMF, German, Italian, French and Danish embassies. DPHK assigned specific development partners to support the proposal writing: WHO, UNICEF, CHAI, USAID/MCSP. The DPHK being members of the HSCC also provided feedback, guidance and critical input to the proposal during the application process.

Civil Society Organizations working in Health were engaged during this application process with leadership of CSO umbrella organization (HENNET) and Kenya Aids NGO Consortium (KANCO) actively participating in drafting. The Ministry of Health also engaged the following CSOs: AMREF and Catholic Relief Services.

The Ministry of Health also worked closely with the Gavi secretariat in the development of the proposal who offered clarity, high level guidance and general support in the application process.

The drafting of the application was done through workshops and several consultative meetings with the different stake holders groups. The workshops were dedicated to group work in which

participants were assigned to specific groups based on their expertise and comparative advantage. An analysis of the immunization program performance was undertaken to identify key gaps and bottlenecks. Priority bottlenecks to be addressed through this application were identified. From these discussions a list of key thematic areas emerged and consensus was reached on the objectives, the budgetary ceilings, key activities to address bottlenecks and the strategic implementation process of the Gavi HSS grant. Considerable effort was made to ensure that the proposed activities were linked to an output that would have a high impact to the immunization system and would be viable and sustainable after the grant.

The proposal was shared with National Immunization Technical Working Group for review before sharing with the HSCC/ICC for their review and inputs. The advice and feedback form HSCC/ICC were incorporated into the draft and subsequently forwarded for review and signing by the Minister of Health and Finance. The members of the HSCC signed off the proposal before submission to GAVI on 15th January 2016.

3. Signatures

3a. Government endorsement

*Include Minister of Health and Minister of Finance endorsement of the HSS proposal – **Mandatory Attachment #2.***

We, the undersigned, affirm that the objectives and activities of the Gavi proposal are fully aligned with the national health strategic plan (or equivalent), and that the funds for implementing all activities, including domestic funds and any needed vaccine co-financing, will be included in the annual budget of the Ministry of Health.

Minister of Health (or delegated authority)	**Minister of Finance** (or delegated authority)
Name: Dr Cleopha Mailu	Name: Henry Rotich
Signature:	Signature:
Date:	Date:

3b. Health Sector Coordinating Committee (HSCC) endorsement

*Include HSCC official endorsement of the HSS proposal – **Mandatory Attachment #3***

Include a signature of each committee member in attendance and date.

Mandatory Attachment #3: HSCC Endorsement of HSS Proposal

We the members of the HSCC, or equivalent committee met on the _____ (date) to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes of the meeting endorsing this proposal are attached to this application.

Please list all HSCC members	**Title / Organisation**	**Name**	**Sign below to confirm:**	
			Attendance at the meeting where the proposal was endorsed	**Endorsement of the minutes where the proposal was discussed**
Chair				
Secretary				
MOH members				
Development partners				
CSO members				
WHO				
UNICEF				
Other				

4. Executive Summary *(Maximum 2 pages)*

Provide an executive summary of the application.

Since 2013, Kenya has been implementing a devolved system of governance with health services largely devolved to 47 County Governments that receive predictable funding from National Budget. While Kenya has a fairly well developed immunization system, devolution of health services has compounded challenges facing delivery of quality immunization services which is evidenced by declining coverage for key antigens even in regions that have previously performed well. There is however evidence that previously marginalized areas (e.g. Turkana County) are increasingly investing in expanding access to services thereby contributing to improved immunization performance. This proposal which has been developed following extensive consultation and with participation of County Health Management Teams, seeks to address selected health system bottlenecks that have been identified in the recent Effective Vaccine Management Assessment (2013), Immunization Financing review (2014), Health Systems analysis conducted in the previous GAVI HSS proposal (2014), Joint Appraisal (2015), and other health system assessments including i) Post introduction evaluation of Rotavirus and Measles Second Dose (2015) ii) comprehensive Multi Year Plan (2015-2018) iii) the Kenya Health Sector Strategic and Investment Plan (KHSSP) and its predecessor document the iv) National HRH Strategic Plan (2009 - 2012).
Lack of Clarity on roles and Responsibility between National and County governments; Inadequate technical and managerial capacity at the county level to fully support EPI implementation; Inadequate and delayed financing for immunization; Lack of adequate knowledge by caregivers and communities on return dates, complacency amongst caregivers; reduced risk perception of Vaccine preventable diseases, amongst communities and select professionals and religious groups leading to vaccine hesitancy; Health worker knowledge gaps and attitude; Inequity to access to immunization due to socio-economic, geographic and physical barriers; Inadequate cold chain capacity at subnational level; Weak Stock management; challenges linked to last Mile delivery of vaccines; Data quality challenges and inadequate capacity of users to analyse and use data for decision making are the major bottlenecks that will be addressed under this proposal.

The bottlenecks were identified across virtually all the health system building blocks and those that are selected to be included in this proposal are aligned with at least two or more of the following attributes:(1) A high potential for garnering sustainability. (2) Achievable impact within the lifetime of the funding period. (3) Synergies with other prioritized strategies and ongoing broader health system initiatives as well as building on previous GAVI support.

By addressing the priority bottlenecks outlined, this proposal aims at achieving the following objectives that will contribute to improved immunization outcomes:

1) To accelerate strong political engagement, improve governance and financial sustainability for immunization outcomes in line with devolution by 2019
2) To achieve equitable access to and utilization of routine immunisation services in 16 focus counties by 2019
3) To strengthen immunisation supply chain and logistics system (iSCL) for availability of quality vaccines and immunization supplies at national and subnational levels by 2019
4) To strengthen immunisation data management and information systems for timely decision making at national and subnational level by 2019

Strong political engagement will entail advocacy with the 47 county governments with a view to create ownership and investment in the immunization program. Advocacy will also contribute to establishing a culture of coordination, accountability for results and evidence based planning for resources. This will subsequently facilitate regular review of data and progress on implementation and feedback to key stakeholders including community members.

As well as contributing to the strategy of universal health coverage (UHC), this proposal aims to reduce the equity barriers to access of immunization services among remote and underserved populations including the inner city urban homesteads. Sixteen (16) high priority counties have been identified through a criteria based on global multi-dimensional poverty index[1], number of un-immunized children and immunization coverage. New static and outreach service points will be set-up as part of the Reach Every Child/Community (REC) strategy. In addition, a comprehensive approach is advocated for to ensure issues such as health facility opening times, male inclusion in health promotion messages and their participation are not limiting factors to service use.

The strategic activities to strengthen the supply chain at various levels will include procurement of cold chain equipment for expansion and replacement of old and non-functional. The allocation is based on the 2014 cold chain equipment inventory. Funding for the gap will be requested in a proposal under the Gavi cold chain equipment optimization platform scheduled for later in 2016.

Data management will be strengthened through routine data quality assessment and review on a regular basis at county level as outlined in the 2014 data quality improvement plan. The plan will specifically focus on i) updating current SOPs and streamlining compliance to these ii) capacity strengthening for improving data accuracy, analysis and interpretation iii) availability of paper based tools iv) improvement of coverage of electronic based data bases.

This GAVI Health System Strengthening Support Application has been carefully developed by a consortium of immunization stakeholders in Kenya under the leadership of the Ministry of Health. The development of this document engaged a wide range of development partners for health in Kenya (DPHK) – AMREF, The Red Cross (Kenya Red Cross and American Red Cross, CHAI, JICA, JSI, UNICEF, USAID/MCSP, WHO and a number of GAVI technical advisors. CHAK, LDS Charities, HENNET, KANCO and KCCB have participated actively at all stages of the proposal development. The proposal has brought on board full participation of ICC, HSCC, and complete indulgence of Ministry of Health and National Treasury leadership.

This application document has been developed in line with the new devolved health system in Kenya as per the 2010 constitution. County Directors of Health for Kajiado, Migori, Nakuru and Muranga Counties participated in the development of this proposal. Various stakeholder meetings with counties were held where immunization performance was reviewed and challenges and actions identified including mobilization of additional resources for priority interventions. The application is also aligned with the timelines and priorities of the Kenya Health Sector Strategic, Investment Plan (KHSSP 2014-2018) and the comprehensive Multi-Year Plan 2014/15-2018/19. The monitoring indicators reflect those identified in the national M&E framework. The intermediate results indicators included as part of the grant monitoring represent those with the largest expenditure.

The principal recipient of the grant will be the National Treasury while Ministry of Health will be the principal implementer. Funds for activities to be implemented by CSOs will be channeled to HENNET by GAVI. HENNET in collaboration with the Ministry of Health will select Civil Society Organizations competitively to participate implementation of the project alongside Ministry of Health. To ensure smooth implementation of activities a risk analysis complete with mitigation measures has been done for various operational levels.

[1] Attachment 26_Criteria and final list for selecting targeted counties

A comprehensive budget totaling US$ 20,224,608 for various activities for both National and county levels has been done with standardized unit costs. Each key activity in each objective area has been well captured with budgetary implications clearly indicated. Various supporting documents have been annexed in this application for ease of reference and other necessary action. Key documents include Kenya Health Sector Strategic and Investment Plan (KHSSP 2014-2018), comprehensive Multi-Year Plan 2014-2019 and Health Monitoring and Evaluation Plan among others. It is envisaged that the immunization outcomes to be realized through implementation of this Health Sector Strengthening Support proposal will contribute to improving child survival.

5. Acronyms

Provide a full list of all acronyms used in this application.

Acronym	Acronym meaning
AEFI	Adverse Events Following Immunization
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ANC	Ante-Natal Clinic
ART	Anti-Retroviral Therapy
AWPB	Annual Work Plan and Budget
BCG	Bacille Calmette-Guerin (Vaccine)
CBK	Central Bank of Kenya
CCE	Cold Chain Equipment
CCL	Cold Chain Logistics
CHAI	Clinton Health Access Initiative
CHAK	Christian Health Association of Kenya
CHC	Community Health Committee
CHEW	Community Health Extension Worker
CHSIP	County Health Strategic Integrated Plan
CHV	Community Health Volunteer
CIDP	County Integrated Development Plan
CME	Continuous Medical Education
cMYP	Comprehensive Multi-Year Plan
CSO	Civil Society Organisation
CU	Community Unit
CVS	Central Vaccine Store
DFH	Division of Family Health
DHIS	District Health Information System
DHL	Deutsche Post
DHS	Demographic and Health Survey
DPPHS	Directorate of Preventive and Promotive Health Services
DPT	Diphtheria, Pertussis, Tetanus vaccine
DPT-HepB-HiB	Diphtheria, Pertussis, Tetanus, Hepatitis B, Haemophilus influenza type I vaccine
DQA	Data Quality Audit
DQS	Data Quality Survey
DQSA	Data Quality Self-Assessment
DSA	Daily Subsistence Allowance
DTP	Diphtheria-Tetanus-Pertussis
DVS	District Vaccine Store
EMR	Electronic Medical Record
EPI	Expanded Program on Immunisation
EVMA	Effective Vaccine Management Assessment
FIC	Fully Immunised Child
GAVI	Global Alliance for Vaccines Initiative
GFATM	Global Fund to fight AIDS, TB and Malaria
GoK	Government of Kenya
HCP	Health Care Provider
HENNET	Health NGOs Network
HF	Health Facility
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HR	Human Resource

HRH	Human Resources for Health
HSCC	Health Sector Coordinating Committee
HSS	Health Systems Strengthening
ICC	Interagency Coordinating Committee
ICT	Information Communication and Technology
IFMIS	Integrated Financial Management Information System
IPC	Inter-personal communication
IPT	Intermittent preventive treatment
iSCL	Immunisation Supply Chain Logistics
JANS	Joint Assessment of National Strategy
JAR	Joint Assessment Report
KANCO	Kenya AIDS NGOs Consortium
KCS	Kenya Catholic Secretariat
KDHS	Kenya Demographic and Health Survey
KEPH	Kenya Essential Package for Health
KES	Kenya Shilling
KHSSP	Kenya Health Sector Strategic and Investment Plan
KNBS	Kenya National Bureau of Statistics
KPI	Key Performance Indicator
LoU	Letter of Understanding
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Programme
MDA	Ministry, Department and Agencies
M&E	Monitoring and Evaluation
MFL	Master Facility List
MI	Micronutrient Initiative
MICS	Multi Indicator Cluster Survey
MLM	Middle Level Management course
MNCH	Maternal Neonatal and Child Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
MOF	Ministry of Finance
NCCK	National Council of Churches of Kenya
NGO	Non-Governmental Organisation
NHSP	National Health Sector Plan
OPV	Oral Polio Vaccine
PBF	Performance Based Funding
PCV	Pneumococcal Vaccine
PFM	Public Financial Management
PIU	Project Implementation Unit
PMTCT	Prevention of Mother to Child Transmission
PMU	Project Management Unit
PPOA	Public Procurement Oversight Authority
PPM	Planned Preventive Maintenance
PS	Principal Secretary
REC	Reach every Child/Community
RED	Reach Every District
RFQ	Request for Quotations
RMNCAH	Reproductive Maternal Neonatal Child Adolescent Health
RVS	Regional Vaccine Store
SMT	Stock Management Tool

SOP	Standard Operating Procedure
TB	Tuberculosis
TNA	Training Needs Assessment
TOR	Terms of Reference
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
USAID	United State Agency for International Development
USD	United States Dollars
UVIS	Unit of Vaccines and Immunisation Services
WB	World Bank
WHO	World Health Organisation

PART B: BACKGROUND INFORMATION

6. Description of the National Health Sector *(Maximum 1 page)*

*Provide **Attachment #8**: NHSP or equivalent and reference, which sections describe the national health sector. If no existing approved national document describes the national health sector, provide a concise overview of the national health sector.*

Legal, policy and regulatory, including laws/ policies guaranteeing rights to health care: The constitution of the Government of Kenya (2010) commits to providing equitable, affordable and quality health care of the highest standard to all Kenyans. According to schedule 4 of the constitution, health service delivery including promotion of primary healthcare is devolved to the 47 counties with the national government mandated to provide National Referral health facilities, health policy and legal oversight and budgetary support to the devolved units through regular domestic budgeting process. The funds from National budget are however not earmarked as counties are required to develop their own integrated plans. The overall National Development Plan "Vision 2030" focuses on attaining two critical obligations of the Health Sector: a rights-based approach and ensuring health contribution to the Country's development. The KHSSPIII and the Joint Program of Work and Funding are aligned to both the Constitution and the "Vision 2030". The Health Sector Annual Work-Plans priorities at national and county level are in turn guided by the KHSSP III. The national immunization policy guidelines bind both the national and county level in the provision of vaccination services. This policy is due for review to include new vaccines introduced and clarify the roles of the two levels of government. Currently the harmonized Health Bill that covers all facets of the various segmented health acts related to human resources and service delivery is before Parliament for enactment.

The HSCC chaired by the Principal Secretary for Health with membership of heads of development partners, provides overall coordination oversight and leadership for the Health Sector. The ICC reports to the HSCC and is tasked to provide Technical guidance to health programs that are managed through Technical working groups which guide decisions by program leads. The NITAG has been constituted as an independent advisory body to provide technical guidance to the Immunization Program including introduction of new vaccines.

There are a number of regulatory bodies and mechanisms in place that are intended to protect the public from defective products:

1) The Pharmacy and Poisons Board (PPB) operating under Cap 244 of the laws of Kenya ensures that medicines and Biological products including vaccines manufactured or imported into the country are of high quality, safe and efficacious.
2) The National Quality Control Laboratory (NQCL)[2] is the technical quality-testing arm of the Board
3) The Unit of Vaccines and Immunization Services also partners with Kenya Medical Research Institute on testing of Surveillance samples collected from the field.

Service delivery, including public, private and CSOs:

The current Kenya Health Sector Strategic and Investment Plan (KHSSP 2014-2018) will accelerate the attainment of Universal Health Coverage by scaling up coverage of the Kenya Essential Package of Health Services (KEPH) as well as reducing access barriers and addressing equity barriers to access to health care services. The scope of the KEPH reflects major health risk factors and causes of

[2] This laboratory is WHO pre-qualified

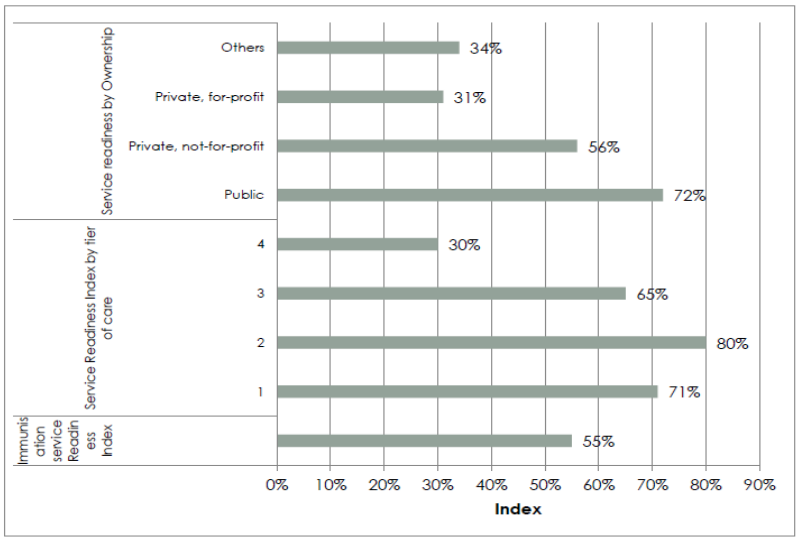
mortality and morbidity, conditions that are targeted for eradication, elimination and or control through prevention by immunisation. The KEPH focuses on four main strategies viz. 1) Accelerating the reduction of communicable diseases through immunisation, child health services, screening for communicable conditions, antenatal care, prevention of mother to child HIV transmission (PMTCT); integrated vector management, good hygiene practices; HIV and STI prevention, port health and the control and prevention of neglected tropical diseases 2) Halt and reverse the rising trend of non-communicable diseases by screening for NCDs; promoting workplace health and safety; enhancing food quality safety and hygiene 3) reducing the burden of violence and injuries 4) Minimizing exposures to health risk factors through health promotion, sexual education, infection prevention and control, micronutrient deficiency control and physical activity

There are four tiers of service delivery (4 – Tertiary referral services; 3 – primary referral; 2 – primary care; 1 – community units) differentiated by infrastructure, equipment and human resource investment levels and the catchment population served. The community unit is composed of Community health committee (CHC) that provide coordination oversight, Community Health Extension Workers (CHEW) employed by government and attached to a health facility and community health volunteers (CHVs). CHEWs and CHVs are individuals working within the mainstream health system to implement the community health strategy. They are majorly engaged by and supported by CSOs since they have not been fully absorbed by the MoH in most counties. CHEWs provide supervisory oversight to community health volunteers (CHV) and linkage to the health facilities in the catchment area. The community health volunteers are charged with the task of demand creation and promotion of basic health services including immunisation. The CHVs maintain household registers that contain information on household members; identify, track and refer children who have missed scheduled immunization visits. A total of 3959 functional CU are established nationwide, providing a vital base for the demand creation platform. The Health Network for NGOs and CSOs (HENNET) has membership of both facility and non-facility based providers.

There are currently 10,068 health facilities in Kenya. Most of the service delivery is provided by the public sector (49.8%), followed by private for profit (31.7%), private not for profit (16.6%). Only 38% of required facility based service units are in place with the largest gaps existing for lower level structures. Slightly over half of the facilities (57%) are functionally equipped to provide the Kenya Essential Package for Health (KEPH) with 63 % of these facilities equipped to provide immunisation services. The Ministry of Health's Unit of Vaccines and Immunization (UVIS) supports all the 5,874 public and private facilities that offer free immunization services. Standard immunization practices are guided and ensured by the National policy and other guidelines issued by the Unit from time to time. In addition, UVIS sets equipment specifications and data collections tools templates. UVIS procures all the EPI vaccines and delivers them to 9 Regional Depots from where Counties pick for delivery to the Sub-county (District) Vaccine stores before delivery to health facilities on monthly basis. The Unit also supplements the County efforts by procuring Syringes, cold chain equipment (CCE), Safety boxes and printing of an assortment of data collecting tools. Training is a key function of the Unit though it is now limited to senior staff at sub counties who in turn cascade the trainings to the lower levels. While Kenya has a well-established network of immunizing facilities with high community understanding of the benefits of immunization that has contributed to minimal refusal, an estimated 3 in 10 children are not fully vaccinated by first birthday. Children in urban, central region most likely to have received vaccination. Children born in Northern Kenya and those born to mothers with no education are most at risk of not receiving all scheduled basic childhood vaccines (KDHS 2014). Analysis of administrative data shows that an estimated 356,000 children are not effectively reached with the 3rd dose of Pentavalent vaccine with half of these children residing in only 57 or 20% of sub-counties (districts). Forty-two percent or 149,079 of the under vaccinated children are in the 16 counties targeted for support through this proposal. Only 47% of sub counties report coverage above 80% for Penta 3 (JRF 2014).

Although the MOH goal is to ensure that every Kenyan lives within 4 kms of a health facility in some regions the coverage is only one health facility per 50-200Kms[3]. Moreover, there is also a variation in the service readiness of health facilities to provide the KEPH. The Private not-for-profit facilities have the highest general readiness index (65%) compared with the public (57%) and Private for-profit (54%). There is no significant difference between urban and rural health facilities[4]. A similar picture is seen for immunization readiness as shown in the figure below.

Figure 28: Immunization services readiness in Kenya



KEY: 1 – Hospital; 2 – Health Centres; 3 – Dispensaries;4–Medical Clinics,Stand-Alone HTC/VCT&Others

Workforce and human delivery, including the role of community health workers:

Kenya's Human Resources for Health are way below the WHO recommended per capita ratio for nurses and midwifes of 23 per 10000 population. The nurse population ratio for Kenya is 3 per 10,000 (SARAM 2013). With the exception of the management cadre, there is no consolidated information of how many HRH work in immunization especially at service delivery. The lack of this information makes it difficult to fully appreciate and plan to address these HR gaps in a coordinated way. A national human resource for health strategic plan (2008 – 2012) was developed and key strategies to improve HRH was through recruitment of 7,588 new health workers and to support the management of the decentralization of HR function.

There is a wide variation in the distribution of health workers with the rural and remote areas failing to attract staff mainly due to poor social infrastructure. On the other hand, the highest concentration of doctors, nurses and clinical officers is skewed towards the Western, Nyanza and Central regions. In general, tertiary and secondary hospitals fill their human resource requirement better than the lower tiers. There is also a wide variation in cadres per capita – the greatest workload reflected among health support workers (e.g. medical engineering, health records technicians) at less than 0.2 per 10,000. Staff absenteeism in 2013 was relatively low (15.4%) and the top three reasons for absenteeism in order of magnitude were i) in training ii) on maternity/sick leave iii) on official mission.

[3] Kenya National Health Sector Strategic and Investment Plan II
[4] Kenya Health Sector Strategic and Investment Plan 2014-2018

Procurement and supply chain management system, including any cold chain equipment policy:

Procurement in the health sector must comply with the Public Procurement and Disposal Act of 2012 and the Letter of Understanding (LoU) between the Government of Kenya (GoK) and Partners. The Public Procurement Oversight Authority (PPOA) is mandated to ensure ethical practice in all public procurement processes. There main procurement mechanisms: i) Tenders (Open or Restricted) ii) Request for Quotations (RFQ). The procurement of costly items such as vehicles is ordinarily through open tenders. Vaccines and cold chain equipment for the immunization program are often procured through UNICEF that has extensive expertise on these specialised commodities.

WHO prequalifies all vaccines, injection devices and cold chain equipment that are procured into the country and their specifications adhere to those of the national regulatory authorities. In order to ensure quality, standardization and value for money, bulk procurement of vaccines and cold chain equipment are procured through UNICEF that has extensive expertise on these specialised commodities.

The 2013 EVMA report showed that up to 50% of district stores and health facilities had inadequate cold chain capacity. Subsequently an improvement plan including the mobilisation of resources for cold chain expansion, improvement and maintenance was developed based on this assessment. To date, the country has implemented 50% of the planned interventions including procurement of cold chain equipment and spare parts through support of KFW, MoH and UNICEF in 2014. The cold chain inventory of 2015 showed a requirement of 1168 solar direct drives for facilities with no electricity and 3985 ice lined refrigerators are required for facilities that have electricity or have outdated absorption fridges

The devolution of health services places the responsibility for the procurement of injection devices and cold chain equipment at the county level resulting in the loss of economies of scale. In addition, there are challenges for maintaining quality and standards largely owing to the absence of adequate specialised technical and managerial skills at the county level. This highlights the need of building the capacity at county level to assure value for money while maintaining quality and standards as outlined in the National Immunization policy. Investment in recruitment, training and operational support to cold chain maintenance technicians especially in the hard to reach regions is also needed to ensure effective and optimal functioning of cold chain equipment. A comprehensive cold chain inventory will be needed in 2018 to clearly understand the improvements in cold chain capacity.

All vaccines and supplies are cleared through customs by an out-sourced clearing and forwarding logistics company, which delivers them to the Central Vaccine Stores (CVS). The Unit of Vaccines and Immunization Services (UVIS) has the responsibility for vaccine receipt, storage at the CVS and the subsequent quarterly distribution to regional vaccine stores (RVS) through outsourced transport services. Sub counties then collect vaccines from the RVS every three months, but this is dependent on their storage capacities. Finally, the immunizing health facilities (HFs) collect their monthly supplies of vaccines from their respective sub county stores. Injection devices for co-financed vaccines are received centrally by the Kenya Medical Supplies Agency and distributed directly to the sub county stores.

The County governments are responsible for ensuring access to all immunization supplies for their citizens however few counties have the people, the processes, the technology, or the capacity to effectively manage immunization supply chain. The national level is currently working on improving the immunization supply data by deploying the online stock management tool (SMT) beyond the central and regional stores to the sub county levels and eventually to service facilities to leverage vaccine consumption data is reported in DHIS2. Because the quality of data that is reported in the DHIS2 has wide discrepancies for some indicators[5], capacity strengthening will be

[5] Data Quality Assessment Report 2014

factored in to ensure that facilities both improve the accuracy of reporting and use of data for decision-making.

Health Information systems including the frequency of EPI reporting: The KHSSP details the common data architecture that will promote common data collection and sharing mechanisms among all health sector implementers in the public and private sector. The data sources for the Health Sector are health facility-generated data, vital events, disease surveillance, regular surveys including DHS and research. Most of the health and related service outcome indicators including immunization outcome indicators are collected using routine Health Information System data through DHIS2. This is a web-based tool that is designed to facilitate generation, analysis and dissemination of quality health information. Data from health facilities is transmitted from Health facilities to sub-counties where it is entered into DHIS2 at Sub-County level on a monthly basis. This data then becomes available and accessible online to all registered users. The system users are able to utilize in-built data analysis provisions for each level. Good quality routine HIS data delivered in a complete and timely manner can be used in surveillance of diseases of public health importance, to prevent or control outbreaks, as well to strategize on adequacy of service delivery under the various disease programs. The system has in-built data quality checks, however there is need to strengthen the data quality controls as well as timeliness and completeness of reporting. Back-up of data entered into the system are maintained at the national level. National level and Counties are expected to conduct regular data analysis to inform performance review meetings and decision making. Adverse Events following Immunization (AEFIs) are reported immediately on occurrence. Annual Data Quality Audits and performance review meetings are priority investment during the period of KHSSP III. Data quality self-assessment (DQS) tools are available and are being used to generate information at County and Sub-County levels. The National Data Quality Improvement plan is available.

Health and community systems financing: The increase in Total Health Expenditure from USD17 to USD 50 per capita in the last five years contributed to the substantial reduction in out of pocket expenditure. The approved estimates for national Ministry of health was at US$ 93.6 million in 2012/13. For the FY 2013/14, the approved budget reduced to US$ 45 million due to the separation of government functions into national and county. County Allocation to health increased from 13% in 2013/14 to 22% in 2014/15. Substantial variation in the allocation of budgets to health by counties is noted. In 2014/2015 financial year 29 counties allocated at least 15 percent of their budget to health. The bulk of county health budget in 2013/14 to 2014/15 was spent on personnel emoluments (Controller of Budget Kenya). Overall, the bulk of funding is largely allocated to three main diseases – HIV, Tuberculosis and Malaria, and these are mostly for diagnosis and treatment, rather than for preventive measures. The immunization program is poorly funded to support the operational cost and funding is mainly for procurement of commodities. Traditional vaccines such as BCG, Measles, OPV and TT are fully funded by the Government of Kenya (GoK), while the DPT-HepB-Hib (Penta), PCV, Rota and Yellow Fever vaccines are co-financed by GAVI and GoK.

The limited funding for operational costs hampers service delivery through outreach to remote rural communities negating the government's intention to provide equitable services to the population. In addition, the paucity of operational funds demotivates the health workers and reduces opportunities to achieve immunization targets.

To promote equity in health care financing, there exists a national health insurance scheme (NHIF). NHIF registers all eligible members from both the formal and informal sector. For those in the formal sector, it is compulsory to be a member. For those in the informal sector and retirees, membership is open and voluntary.

7. National Health Sector Plan (NHSP) and relationship with cMYP (*Maximum 2 pages)*

Describe the relationship of the cMYP to the national health strategy.

*Provide: **Mandatory Attachment #8**: NHSP and **#11:** cMYP; and if available: **Attachment #18**: Joint Assessment of National Health Strategy (JANS); and **Attachment #19**: Response to JANS.*

The priorities and targets of the comprehensive Multiple Year Plan (cMYP) 2014/15-2018/19 are aligned to those of the Kenya Health Sector Strategic plan (KHSSP-ÌÌÌ) and several national health strategy and policy documents. KHSSP III 2012 – 2017; Kenya Health policy 2012-2030, Vision 2030, Constitution 2010 and other global health commitments of the country in both strategic content and time frames.

The KHSSP III includes two main indicators related to immunization i) the % of children who are fully immunized and ii) the % of facilities providing immunization. The cMYP provides a clear account of the factors for the low baseline average (79%) for % Fully Immunized Child (FIC) in the KHSSPIII. In terms of absolute numbers 450,000 children out of a surviving cohort of 1.5 million are not fully immunized. The reasons outlined are i) geographical – 5 counties vaccinate less than 50% of children under 1 year and 27 sub-counties (districts) do not attain 80% of 3 doses of DPT ii) socio-economic – those who are not immunized are – from poorest households, belong to less educated mothers and those living in urban informal settlements. Furthermore, the cMYP notes that there has been a decrease in performance between 2008 and 2014. Addressing the factors related to disparities in access will be critical if the projected annual targets in the KHSSPIII reaching 90% in 2018 are to be attained.

All the provider based immunization system challenges outlined in the cMYP have also been highlighted in the KHSSPIII:

1) Governance – understanding of roles and responsibilities between county and national level; minimal engagement of civic partners to advocate for EPI issues;

2) Financing: in addition to underfunding the cMYP explains the factors that compound the limited financing i.e. delays in disbursement between different levels of government to lower levels; further reductions in health funding at the county level because of reprioritization to other competing priorities

3) HR: inadequate staff and weak management, failure to attract staff to county level

4) Information and research: disparities in data and limited critical capacity to analyse existing information

5) Supply chain: inadequate capacity for supply chain and need to address issues of safety and quality; vaccines are available at only 85% of primary care facilities and 80% of hospitals.

The strategies identified in the KHSSPIII are aimed at increasing access to immunization services. The KHSSPIII intends to address imbalances in geographical distribution of facilities across regions as well as non-functional inputs (equipment etc.); target the hard to reach northern arid and the urban informal populations, as well as providing primary care services free at the point of use. The demand for service will be created through improving awareness of the services and ensuring the quality of care.

Strengthening immunization system is central to the KHSSPIII's strategic objective of accelerating the reduction of the burden of communicable diseases and conditions. In the KHSSPIII all vaccine preventable diseases are part of the Kenya Essential Health Package. In immunization, polio is targeted for eradication, tuberculosis (TB) and other vaccine preventable diseases are targeted for control whilst NNT and measles are targeted for elimination.

Implementation of the cMYP is reliant on the planned investments of KES 28 Billion for immunization over the period of the KHSSPIII, will help maintain 100% stocking for health products. The community units (CU) and county management teams established in the context of devolution will also be vital in bridging access gaps in remote areas as outlined in the Health sector strategic Plan.

8. Monitoring and Evaluation Plan for the National Health Plan *(Maximum 2 pages)*

Provide background information on the country M&E arrangements.

Monitoring and Evaluation Plan: The current M&E plan runs from 2014-2018 and details the common data architecture that promotes common data collection and sharing mechanisms among all health sector implementers in the public and private sector at county and national level. The M&E framework aims to provide 'One functional, sector-wide Monitoring and Evaluation system for improved decision-making, transparency and accountability in health' and seeks to 'Promote integration of health information systems and Standardize M&E procedures at all levels of the health system', in line with the National development agenda Vision 2030 and KHSSP III. Having a common M&E framework will enhance a strong partnership and improve coordination among sector stakeholders.

Two evaluations will be carried out during the period of KHSSP III: i) Mid -term review – to review progress and impact attained at the Mid Term of the strategic plan, and will coincide with the End Term of the Millennium Development Goals (MDG) in 2015. The Mid-Term Review report shall also feed into the MDG evaluation report for Kenya ii) End term evaluation– to review final achievements of the sector, against what had been planned.

On a quarterly and annual basis, the different levels of government report progress on the targets set in their work-plan. The Annual County Health Sector Report is developed by the county health stakeholders' forum through a consultative process and presented at a County Annual Health Review forum and the county assembly. The National Annual health sector report is disseminated to all stakeholders in health, including county health management teams for feedback and buy in. The National Annual Health Sector Report contributes to the annual state of health in Kenya report, which is discussed at the national health congress.

Sources of information:

A wide scope of the Health sector data from different sources are outlined below:

i) **Routine health information (Hosted by DHIS2):** Information on Health target and management activities occurring in health facilities, and is collected through the routine Health Management Information System. Data is collected at the service delivery level from all health facilities. Paper based data from health facilities is then transmitted to the sub-county level where the data is then entered electronically into district health information system (DHIS 2).

ii) **Vital statistics information:** Information on vital events occurring in the communities that is collected routinely. These are information on births, deaths and Causes of Death in the community

iii) **Disease surveillance information:** the information fast track system for critical health

events / notifiable conditions occurring in the community

iv) **Survey information:** Service delivery, or investment information on health and related activities occurring in the communities that is collected on a regular basis. These include the Demographic and Health Surveys, AIDS and Malaria Indicator Surveys, Service Provision Assessments, Multiple Indicator Cluster Surveys (MICS), Effective Vaccine Management Assessments (EVMA), Post Introduction Evaluations following Introduction of new vaccines, Availability and Readiness assessments.

All these information sources provide crucial data and information for immunization program monitoring and evaluation in line with the National M&E framework. Gaps however exist in capacity of the country to triangulate and use information from all these sources to improve program performance. Gaps also exist in Data quality for routine data collected through DHIS2. Despite the progress made in the implementation of IDSR in the country, challenges still exist. Some of the challenges are related to the inadequate staffing, insufficient pre-service training on IDSR functions, a high turnover of staff and competing roles for surveillance focal persons. The Government funding for surveillance activities is also inadequate and mostly funded by partner organisations. The lack of consistent government funding has placed a strain on the implementation of IDSR in the country, including scale-up of surveillance and response activities as well as the performance improvement of surveillance and response indicators. Also the implementation of community based surveillance is constrained since it relies heavily on volunteer Community Health Workers.

Monitoring Indicators: A total of 102 indicators are used to monitor the impact, health and related service outcomes, level of investment, inputs and processes of service delivery. Up to 60% of these indicators are measured using routine Health Information System Data. Immunization indicators include: the proportion of children who are fully immunized and the proportion of facilities providing immunization services A core set of 40 indicators are regularly monitored in the M&E framework to determine progress. These indicators are used to calculate indices that reflect progress on specific strategic objectives. The impact, outcome and output targets in the National M&E framework and the National Health Plan specific to EPI service delivery are: Under 5 mortality ratio; % of Fully immunised children; and % of facilities providing immunisation services. In addition, program specific indicators are used for monitoring and evaluation of specific subsector strategic plans.

Adverse Events Following Immunization are reported to the Unit of Vaccines and Immunisation Services using standard AEFI reporting forms. In addition, a monthly summary report on number of AEFIs reported is submitted through the DHIS from each sub-county. UVIS in collaboration with the Pharmacy and Poisons Board (the national regulatory authority) and partners supports the counties in investigating reported adverse events following immunization. A National AEFI Expert Review Committee needs to be put in place to support causality assessment.

Immunization data

Data on routine immunization performance is collected through routine “District Health Information System” (DHIS and surveys. Routine immunization data is reported among other health data using DHIS. “District Health Information System” (DHIS) is an electronic data management system 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 entered electronically. Data is entered electronically at the sub-county level and that data is available in a central server hosted by the national Ministry of Health unit of Health Information System. DHIS provides an opportunity for aggregation of data which is made available to the Counties and national level including other partners. 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. Other surveys that are done include coverage surveys. The last KDHS was conducted in 2014 and the report is available.

Joint annual health sector reviews (JAR): The JAR conducted in 2012 recognized the innovative dissemination of reports and policy dialogue stipulated in the KHSSP. It however highlighted the need to build capacity that will support information generation and dissemination for a bottom-up approach. It also recommended a smaller more manageable set of indicators.

Data quality audit (DQA): The last two DQAs conducted in 2010 and 2014 highlighted critical gaps in the data information systems that would affect the reliability and consistency of routine sources. Such gaps include variable timeliness and completeness of reporting, weakness in use of data for decision making, variation between survey and routine administrative data and lack of data collection and reporting tools. Data quality improvement plan is available to guide interventions aimed at addressing these gaps.

Below are the key findings of 2010 DQA

1) Variable timeliness and completeness of reporting with an average of above 60%. The Lower Eastern part of Kenya had all the three parameters being over 80% while Nyanza and Western had availability and completeness of over 90% though the timeliness was 80% for Western and 78% for Nyanza. The lowest performing region was North Eastern with availability of 79%, Completeness of 65% and timeliness of 69%.

2) Data verification was either over-reported or under-reported for most of the indicators assessed. There was over-reporting for Women of Reproductive Age accessing Family Planning commodities (105%), Pregnant Women receiving IPT2 (103%), Newborns with Low Birth Weight (115%), and PMTCT/ART at 122%. The verification revealed under-reporting of data for four ANC visits and Delivery by skilled health attendants in health facilities (99%) and gross under-reporting for maternal deaths in health facilities (90%).

3) Data verification documents were not always available pointing to issues with storage of records

4) Use of multiple tools to aggregate the data and the lack of data collection tools contributed to discrepancies observed in reported and recounted data

5) Failure to use registers as per instructions was also noted while some indicators were not well understood.

In particular, the 2014 DQA noted that from 2010, there had only been a slight improvement of accuracy of DHIS data against summary sheets despite having qualified Health Records Information Officers entering data due to lack of aggregation instructions and multiple service delivery sites generating data. Furthermore, the low availability of audit documents in private health facilities highlights the minimal inclusion of these facilities in the national HIS.

The 2014 DQA identified system findings that would need to be addressed in order to improve data quality:

1) Lack of training and support supervision for staff handling data, non-medical staff handling data (casuals),

2) Lack of data review measures

3) Complex aggregation procedures

4) Unclear indicator definitions especially for Immunization and HIV/AIDS, Family Planning, Malaria, and underweight with staff not sure what to count

5) Chronic lack of tools results to improvising, lack of instructions especially on summary tools; some facilities not utilizing the standard tools and using those of partners, no written guideline available on data collection, aggregation, and manipulation procedures.

6) In addition, among the 44 health facilities assessed with Electronic Medical Record Systems (EMRs), the majority of them were installed for managing outpatient service utilization and for financial purposes rather than data generation and were either non-functional in data aggregation or malfunctioned when efforts were made to retrieve data.

Data Quality Improvement Plan

A draft data quality improvement plan exists based on a situational analysis undertaken in 2014. The areas identified for improvement have also been captured in the current cMYP and include: i) updating current Standard Operating Procedures (SOPs) and streamlining compliance to these ii) capacity strengthening for improving data accuracy, analysis and interpretation iii) availability of paper based tools iv) improvement of coverage of electronic based data bases, support supervision and data harmonization.

To help improve on the quality of data generated, health workers and managers will be trained on how to conduct data quality self-assessment (DQS), after which they will be expected to conduct data quality self-assessments regularly in order to enhance the reliability of information. In addition, independent Data Quality Assessments (DQA) at the national level. Results from the DQA and DQS will help flag out areas for attention and guide appropriate interventions. Such areas will include:

- Training of all health workers involved in data management to improve data management capacity.

- Supportive supervision

A pilot on electronic registers at health facility level will help to assess the feasibility and effectiveness on large-scale implementation. There is ongoing engagement of partners such as UNICEF, WHO, CDC and the Government of Kenya to secure commitment to allocate resources to implement the draft data improvement plan.

Comparison between survey and routine administrative data

The immunization coverage in the Demographic Health Survey DHS is higher for most antigens compared to administrative data as shown in the table below. The reasons for the discrepancy is not clear but may be attributed to data quality issues, denominator challenges or survey methods. There exists high number of under vaccinated children which has resulted in sporadic outbreaks of vaccine preventable diseases such as polio and measles. WHO and UNICEF estimates provide data closer to the administrative data. Instituting quality improvement measures in the administrative data can close the 5-10% difference in the two data sets and provide better accuracy in routine monitoring results.

Comparison performance Kenya Demographic Health Survey Coverage Vs Routine immunization 2014

Antigen	**KDHS (%)**	**Administrative Data (%)**
BCG	96.7	84
OPV1	98	88
Penta1	97.5	86
Penta 3	89.9	81
Measles	87	77
FIC (all antigen)	75	74

*Provide **Mandatory Attachment #9:** National M&E Plan (for the health sector/ strategy**),** as well as any sub-national plans, as relevant**.** If this does not exist, explain how the National Health Plan is currently monitored and provide a timeline for developing an M&E Plan.*

*If available, provide **Attachment #16:** Data quality assessment report; and **Attachment #17:** Data quality improvement plan.*

***Pooled fund** applicants are required to attach the National M&E Plan and any documentation on the joint review process, including terms of reference, schedule etc.*

9. Alignment with existing results based financing (RBF) programmes (where relevant) *(Maximum 1 page)*

Indicate whether your country will align HSS support with existing results based financing (RBF) programmes.

If yes, provide ***Attachment #30:*** *Concept Note/ Programme design of relevant RBF programme, including Results Framework and Budget.*

The World bank supported RBF program is yet to be operationalized in Kenya. This proposal is not linked to the proposed RBF but it will complement the attainment of immunization outcomes in the RBF target counties.

PART C: APPLICATION DETAILS

10. Health System Bottlenecks to Achieving Immunisation Outcomes *(Maximum 3 pages)*

Provide a description of the main health system bottlenecks. If such analysis has recently been conducted, attach ***Optional Attachment 33:*** *Health system bottleneck analysis.*

While Kenya has a fairly well developed immunization system, devolution of health services has compounded challenges facing delivery of quality immunization services which is evidenced by declining coverage for key antigens even in regions that have previously performed well. There is however evidence that previously marginalized areas are increasingly investing in expanding access to services thereby contributing to improved immunization performance. Immunization system bottlenecks have been identified following review of recent Effective Vaccine Management Assessment (2013), Immunization Financing review (2014), Health Systems analysis conducted in the previous GAVI HSS proposal (2014), Joint Appraisal (2015), and other health system assessments including i) Post introduction evaluation of Rotavirus and Measles Second Dose (2015) ii) comprehensive Multi Year Plan (2015-2018) iii) the Kenya Health Sector Strategic and Investment Plan (KHSSP) and its predecessor document the iv) National HRH Strategic Plan (2009 - 2012)

Leadership and governance:

Devolution has shifted the mandate of decision-making and the bulk of financial resource for health service delivery from the national to the county governments. County Governments are autonomous in the prioritization of developmental goals. In implementing its mandate of policy and strategic guidance, the national level has to deal individually with each of the 47 counties. Whilst the shift in authority is inherently a catalyst for health sector development since it allows decisions to be made closer to the service beneficiaries, a number of challenges need to be addressed before this benefit can be fully realized:

1: A lack of clarity and consensus in roles and responsibilities between the national and county governments with regards to procurement and operational resourcing for EPI

2: Unclear mechanisms for the efficient engagement of Development Partners, Public Private Partners and CSOs in EPI implementation in the context of Devolution, particularly at the sub-national levels

3: Inadequate technical and managerial capacity at the County Level to fully support EPI implementation at the same capacity that had existed at national level

So far these challenges have manifested in a number of inefficient processes including the duplication and/or non-implementation of key responsibilities.

Health Financing: The general underfunding of the health sector in Kenya also affects EPI operational costs, which hampers service delivery even when the prerequisite commodities such as vaccines and cold chain equipment are available. Underfunding for operations has affected service delivery to remote and rural communities, completely undermining the policy intention of Universal Health Coverage and equitable service delivery. Following devolution of health services, delays in financing for vaccine procurement has been witnessed. However, Kenya's economy is reported to be growing rapidly and the country will enter into graduation from Gavi funding supporting the coming years, resulting in increased contribution by the country to the co-financing for its new vaccine procurement. The request for GAVI-HSS support will include strategies with a potential for widespread gains for sustainability.

Health Information system (HIS): Routine HIS generates up to 60% of the data required to monitor and evaluate progress in the sector. Furthermore, the Monitoring and Evaluation (M&E) framework advocates for common data architecture amongst the different users. The motivation for compliance by all users to "one tool" requires that the data being used is reliable and consistent. There are several constraints that would render the HIS unreliable and undermine its use for decision making.

There are parallel information systems at programmatic level and data for the health sector which are hosted in different databases such as human resource for health (HRH), Commodity and logistics supply systems, DHIS2, financial systems, master facility list (MFL), surveillance systems, community health information systems, vital registration system, Kenya National Bureau of Statistics (KNBS), Electronic Medical Records (EMRs) etc. The systems currently are not interoperable. This creates a situation of data redundancy and time wastage in data collection.

1. There are initiatives in place that have the potential to enhance the efficiency of data collection such as mobile technologies (m-Health) and also link various data systems such as Electronic health records (EHRs)/Electronic Medical Records (EMRs). However, the number of EMRs in the country are still minimal and efforts are not well coordinated.
2. There is limited capacity of sub-national level to utilize electronic based systems, to analyze data and use information for decision making
3. Data quality audits are few and far apart. The recommendations are often not fully implemented.

There are limited mechanisms for research to policy action and ultimately not as much demand as expected for data particularly among policy makers and technical managers

4. As a result of devolution of health services since 2013, reporting rates (timeliness and completeness of reports) declined due to human resourced capacity challenges as well as lack of reporting tools in most health facilities and support for data quality audits by counties.

Health Infrastructure: Nationwide, half the physical infrastructure, medical equipment, communication and ICT, and transport is old and dilapidated with no plans for maintenance. Moreover, most of the existing facilities do not conform to current norms and standards. The EPI infrastructure is not exempt and particularly lacks cold chain infrastructure and management systems coupled with the absence of a comprehensive investment plan for replacement, maintenance and expansion of infrastructure. The ASAL regions face the worst of these gaps and are further disadvantaged in the chronic mismatch in the investments between infrastructure, Human Resources and other Health system commodities. Communication and ICT equipment are

limited and medical equipment supplies suffer from lack of comprehensive and coordinated investment. Significant gaps exist in availability of transport and the maintenance of vehicles and equipment. Vaccine deliveries from CVS to RVS are handled by the outsourced agency. However, for the counties and sub-counties, availability of transport is grossly inadequate (refer to EVMA – section 3.4). The 2013 EVMA showed: 1) Insufficient systems for vaccine clearance, temperature monitoring and storage capacity; 2) Wastage rates of BCG and Pentavalent exceed acceptable levels and 3) Inadequate support supervision and skills of managers and caregivers. The Effective Vaccine Management improvement plan (attached) highlights the steps required to improve the logistics and cold chain system.

Human Resources for Health: The national mix and density of skilled human resources including community health volunteers is inadequate to meet the demands of equitably offering the Kenya Essential Package of Health Services (KEPH). Furthermore, there is an inequitable distribution by region and even within regions between urban and rural areas. The frequent internal staff movement warrants replacement with new staff who are not oriented to the service context and frequently lack specific knowledge in EPI operational issues that are needed for effective management of vaccines. The KHSSP and its predecessor document the National HRH Strategic Plan (2009 - 2012) both underscore the following separate challenges:

i) High attrition especially in hard-to-reach areas leading to inequitable distribution of HR and limited access to health care

ii) Out-migration of health staff especially nurses and doctors

iii) Weak human resources management systems

iv) Weak leadership and management capacity

v) Weak human resources information systems

vi) Weaknesses in pre-service and in-service training

vii) Poor sectoral coordination of the HRH agenda

viii) Low compensation and benefits package

ix) Low employee satisfaction level

Service Delivery: Multiple sources, including the post introduction evaluation of Rota/MSD vaccine 2015, Joint Appraisal in 2015, cMYP (2013-2017), Kenya Health policy (2012-2030) and KHSSP III and other operational research demonstrate that service delivery bottlenecks are multilayered and include: i) Local knowledge, attitudes and practices and how affect decision making for service uptake e.g. complacency due to reduced incidence of vaccine-preventable diseases; Lack of knowledge on diseases targeted for vaccination, return dates, correct contraindications; fear of adverse effects; ii) Geographical barriers such as terrain and vast distances between homesteads and service delivery points iii) Institutional delays in accessing services quality of services, poor staff attitude, health worker knowledge gaps and vaccine stock outs); Long queues/waiting time; Inadequate dissemination of information/community involvement; lack of staff motivation;

A combination of these challenges leads to a low uptake of services, missed opportunities and inequities affecting the whole of the health system including immunization. There does exist a national immunization communication strategy, which needs to be adapted to the unique context of each county in order to address issues around demand creation and improved service utilization.

Although significant progress has been made in immunization coverage for both boys and girls over the last decade, geographical and socio-economic disparities are prevalent. An estimated 3 in 10 children are not fully vaccinated by first birthday. Children in urban, central region most likely to

have received vaccination. Children born in Northern Kenya and those born to mothers with no education are most at risk of not receiving all scheduled basic childhood vaccines (KDHS 2014). The socioeconomic disparity is stark with only 62% of children in the lowest wealth quintile being fully immunized at one year as compared to 82% in the highest quintile. Other underserved populations are children residing in the inner city urban homesteads. Analysis of administrative data shows that an estimated 356,000 children are not effectively reached with the 3rd dose of Pentavalent vaccine with half of these children residing in only 57 or 20% of sub-counties (districts). Only 47% of sub counties report coverage above 80% for Penta 3 (JRF 2014). Furthermore, an equity assessment[6] using the multidimensional poverty index indicates that the 16 most disadvantaged counties contribute Forty-two percent or 149,079 of the under vaccinated children.

Medical Commodities and Supply Management: The current levels of investments in Health Products & Technologies represent a major underinvestment in the Health Sector and this is a major hindrance to access.

The underfunding is compounded by weak capacity at the MOH for stock management at sub national level, often resulting in frequent stock out of critical medicines and supplies for MNCH including vaccines and injection devices. Vaccine stock out has been compounded by weak vaccine management including monitoring of vaccine wastage rates. Furthermore, a number of other management gaps increase the potential for unnecessary wastage e.g. vaccine losses have resulted from weak temperature monitoring and response system.

The, country has a draft Cold Chain maintenance and replacement plan which has facilitated resource mobilization and advocacy for the expansion of cold chain capacity. However, the Implementation Plan based on the recommendations of the EVMA was only partially implemented and up to 50% of health facilities face this challenge of aged and inefficient cold chain equipment. The greater burden is skewed towards the underdeveloped and hard to reach regions that are least supported through technical supervision and on-the-job training. Thus the structure of supportive supervision requires strengthening. A related issue is that the Kenya Vaccine Management guidelines are outdated and would need to incorporate SOPs for each level as well as including fund management at the CVS, RVS and DVS.

Arrangements are in place to use alternative transport such as public vehicles and 'borrowing' from other departments in the absence of dedicated EPI programme vehicles. These alternative transport arrangements are not always guaranteed and result in an inadequate and unreliable distribution system. A particularly worrying concern is when hard frozen packs continue to be used for transporting OPV and freeze dried vaccines instead of the policy recommended conditioned icepacks or cooled water packs. Also, for transport from regional to lower levels, both foam and cold boxes are used in the absence of refrigerated trucks.

Pooled fund *applicants are required to provide a reference to the relevant section and pages in the NHSP which outline how lessons learned from the previous NHSP have been incorporated into the current NHSP plan. If available, attach documentation on lessons learned implementation of the pooled funding mechanism, including relevant sections from joint annual reviews (JAR), mid-term evaluations etc.*

[6] Attachment 26_Criteria and final list for selecting target counties

11. Health system bottlenecks to be targeted through Gavi HSS support *(Maximum 2 pages)*

Identify which of the bottlenecks identified in Question 10 above will be targeted through Gavi HSS support.

The bottlenecks to be targeted with GAVI-HSS support are ranked based on their alignment with at least two or more of the following attributes: 1) a high potential for garnering sustainability 2) achievable impact within the lifetime of the funding period 3) synergies with other prioritised strategies and ongoing broader health system initiatives as well as building on previous GAVI support 4) did not replicate other ongoing health system strengthening initiatives. Only activities that attained a rank of '1' were included. This analysis is attached as annex.

Leadership and Governance: **addressing challenges in enabling environment under devolved governance is critical to protect immunization gains made so far and improving performance of the immunization system. The following bottlenecks were identified as priority**

1) Lack of Clarity on roles and Responsibility between National and County government: With clarity of roles and responsibilities a heightened level of efficiency in the resource investments for EPI will be achieved. Tackling this bottleneck is critical to unlocking the current challenge hampering procurement of injection devices, vaccines, funding for operations, technical support by National staff to counties and accountability for results.
2) Inadequate technical and managerial capacity at the county level to fully support EPI implementation: Enhancing the capacity of technical and policy makers will empower them and other stakeholders with current knowledge and evidence on EPI operations so that they can make informed investment decisions. Interventions to address this capacity need is sustainable as it is targeting a critical mass of policy and technical implementers and thus its impact on service delivery should outlast the funding period.
3) Unclear mechanism for efficient engagement of development partners, public private partners and CSO in EPI implementation in the context of devolution at subnational level: Engagement of stakeholders will firm up their commitment and support to the EPI program. This is critical to addressing emerging lack of visibility for the program, reduced risk perception and underfunding. Enhancing CSOs capacity to advocate for EPI issues was particularly successful in the 2007-2010 GAVI-HSS proposal as it was seen to have catalysed an increment in GoK funding for community level financing. This activity will target HENNET, the NGO/CSO umbrella body.
4) Inadequate and delayed financing for immunization: Continued underfunding of the program has contributed to stagnated performance over the last 4 years. This has worsened following devolution of health services. Supporting **high level advocacy and planning meetings amongst key decision makers** (Ministry of Finance, Ministry of Health, Parliamentarians and the County Assemblies) is intended to obtain early buy in for progressively increased and sustained co-financing of EPI activities ahead the GAVI graduation and improved financing for operations.

The following Bottlenecks addressing Service delivery including demand for and utilization of immunization services were identified:

1) Lack of adequate knowledge by caregivers and communities on return dates, complacency and reduced risk perception of Vaccine preventable diseases amongst

communities and select professionals and religious groups. This has contributed to stagnation of Immunization coverage even where access is not a major problem and increasing inequities especially at subnational level. Vaccine hesitancy has emerged in Kenya and needs to be addressed due to reduced risk perception linked to reduced incidences of vaccine preventable diseases. Creating demand for and utilization of routine immunization services amongst community members, caregivers and professional organizations will build on and help to sustain the impact of previous efforts e.g. the USAID supported Global Health Initiative for maternal, neonatal and child health services (2010-2014); current health education programmes offered at all health facilities and the functions of the Community Units that were established in 2008 through the GAVI-HSS (2007-2010).

2) Health worker knowledge gaps and attitude: The EPI program has suffered many years of underfunding with limited technical updates conducted for operational level staff. Following devolution, massive staff movements took place further contributing to high numbers of less skilled health workers providing immunization services. This has contributed to low quality of services that has negatively affected confidence amongst caregivers and ability of healthcare providers and supervisors to implement REC as an equity strategy. Enhancing the knowledge and skills of frontline healthcare providers to create confidence amongst communities on EPI program and deliver quality routine immunization services including addressing Adverse events following Immunization (AEFI) mirrors the capacity building activity for policy and technical leaders in its potential for sustainability. It is also intended to boost the quality of immunization service delivery and attract more users.
3) Inequity to access to immunization due to socio-economic, geographic and physical barriers: Disparities in Immunization coverage persists with regions in northern Kenya that have suffered many years of underdevelopment still reporting low performance. Majority of the 356,000 unreached children are in urban informal settlements, rural areas, poor households and ASAL regions that also suffer insecurity and cyclic emergencies linked to drought and floods. REC is a tried and tested intervention that will supplement the demand creation strategic activity as it also helps to link and track services with communities. Within the REC strategy, immunization performance will be mapped to the lowest level (Community unit). Utilizing the community health strategy (CHC, CHEW and CHVs), household registers will be updated and unreached children mapped/profiled and micro plans developed, implemented and monitored to reach the unreached with routine vaccines through county specific strategies/approaches. While catchment areas with high numbers of unreached children will be of primary focus, special population groups (e.g.: refugee/displaced population in areas suffering insecurity, nomadic populations in Northern Kenya, children in informal settlement) will be identified to ensure inequities are addressed at all levels. The mapping of unreached children will also provide useful information on immunization and other MNCH interventions that will be used for effective advocacy with key decision makers in the 16 counties for sustainable financing and support for immunization.

Medical commodities and supply chain management:

Three critical bottlenecks were prioritized under this health system area: gaps in cold chain capacity especially at subnational level, weak vaccine stock management and last mile distribution challenges.

1) Inadequate cold chain capacity: Immunization services are offered at 60% of the total number of health facilities in the country. Some of the immunizing health facilities lack cold chain to immunize consistently while some health facilities have equipment that frequently

break down, use absorption and domestic fridges that should be replaced to assure vaccine quality. Investing in rehabilitation, expansion and upgrade of the cold chain equipment and accessories will improve the access and quality of service as well as minimising unnecessary wastage of vaccines. This nature of capital investments can last beyond ten years before replacement.

2) Weak Stock management: Kenya has a web based SMT that is yet to be rolled to the sub-counties and health facilities. Vaccine stock data in DHIS2 unreliable. **Improvement of stock management** will minimize wastage and ensure the regular availability of vaccines and reduction in missed opportunities
3) **Last Mile delivery of vaccines:** Absence of dedicated EPI vehicles has hampered timely delivery of vaccines and injection devices to sub-counties and conduct of support supervision**.** This has resulted to occasional vaccine stock outs linked to inability to undertake redistribution at sub-county level. **Strengthening the transport** logistics will supplement improvement in stocks by taking vaccines to the remotest children.

Health Information Systems:

Data quality challenges and inadequate capacity of users to analyse and use data for decision making are two major bottlenecks that will be addressed under this proposal. Unreliable Data is attributed to lack of data capture tools, inadequate staff capacity to analyse and triangulate various sources of data. This has also contributed to disparity between administrative and survey data. These bottlenecks have contributed to weak planning, ineffective resource mobilization and advocacy**.** Addressing data availability, quality and use is crucial to informing decision making and health sector investment including addressing the other bottlenecks mentioned above. Capacity strengthening for improving data accuracy, quality and analysis is to be addressed as part of this proposal. Addressing data quality bottlenecks and data utilization will result to improvement of immunization data with resultant increase in coverage and availability of reliable information.

Pooled fund *applicants are not required to complete this question.*

12. Objectives of the NHSP and application *(Maximum 2 pages)*

Present specific objectives to address the identified bottlenecks, explaining how each aligns with objectives in the cMYP and/ or specific health system strengthening policies/ strategies being implemented. These objectives have to be listed in the same order in ***Attachment #6*** *- Detailed workplan, budget and gap analysis.*

Pooled fund *applicants are not required to prepare separate objectives, rather to list the key objectives from the NHSP, including ones relevant to immunisation.*

Objectives	Description
Objective 1	To accelerate strong political engagement, improve governance and financial sustainability for immunization outcomes in line with devolution by 2019
Objective 2	To achieve equitable access to and utilization of routine immunisation services in 16 focus counties by 2019
Objective 3	To strengthen immunisation supply chain and logistics system (iSCL) for availability of quality vaccines and immunization supplies at national and subnational levels by 2019

Objective 4	To strengthen immunisation data management and information systems for timely decision making at national and subnational level by 2019

13. Description of activities *(Maximum 3 pages)*

Describe the key activities which will lead to achievement of objectives set out in Question 12. Please ensure that the activities described align with the activities that are included in ***Attachment #6*** *- Detailed budget, gap analysis and work plan.*

Pooled fund *applicants are not required to complete this table, but should provide relevant sub-sections of the NHSP focusing on immunisation, including the annual workplan, activities and budget****;*** ***Attachment #34:*** *Pooled Fund Annual Workplan and Budget (AWPB****)*** *and related Terms of Reference*

Objective / Activity	**Explanation of link to improving immunisation outcomes**
Objective 1: To accelerate strong political engagement, improve governance and financial sustainability for immunization outcomes in line with devolution by 2019	
Activity 1.1: Develop an operational Declaration (or MOU) clarifying roles and responsibilities between national and county levels	An operational declaration (or MOU) that clearly outlines with roles and responsibilities between the county and national level will be developed. An EPI stakeholder analysis and mapping will be conducted and updated in order to generate a draft declaration. The declaration once signed and operationalized, will promote financial and technical commitment for EPI activities at both national and county levels as well as reducing duplication of effort, thereby enhancing efficiency of implementation. Funding will be made available for operations such as gas, fuel for support supervision and injection devices. For example, this will lead to less stock-outs of certain types of vaccine injection devices hence improving reliability of immunization services resulting there by causing increase in immunization coverage
Activity 1.2: Build capacity of technical and policy makers to understand and address EPI health sector constraints **The following sub-activities will be implemented under this main activity:** Activity 1.2.a: Strengthen the capacity of technical and policy makers to understand and address health sector constraints in EPI; Develop Training Needs Assessment (TNA) checklist for knowledge, skills and practice in EPI	This activity is intended to equip technical staff and policy makers with skills to use current evidence to generate appropriate local solutions for constraints identified in EPI implementation. A training needs assessment will be conducted, culminating in developing a high level EPI curriculum for policy makers and political leaders at both county and national level. A review and capacity building meeting on EPI and dissemination of EPI performance will be conducted twice a year. This review will be

Activity 1.2.b: Building capacity to generate and share evidence on EPI performance at the county level; Develop a common performance framework for EPI Activity 1.2.c: Rank and award best EPI technical and policy implementers at county and national level (Governor's /County Award) Activity 1.2d: Support Specific Counties to integrate EPI needs within the County Integrated Development plans Activity 1.2e Strengthen Joint planning, joint implementation, M&E and joint re-programming and agreed phase-out strategy; Develop Partners Engagement Framework for EPI Activity 1.2.f Establish, strengthen and launch/re-launch county EPI/RMNCAH stakeholders' forums (ICC) to support joint planning, M&E and joint programming Activity 1.2g: Development of Financial sustainability plans in the context of Gavi graduation; Update financial gap analysis for EPI on a bi-annual basis including identification and commitment of alternative resources - consultant days Activity 1.2h: Undertake immunization equity analysis to generate evidence for advocacy and to inform the immunisation planning and implementation in 16 focus counties.	based on an agreed EPI performance framework for both county and national level A system for ranking and awarding best EPI technical and policy implementers at county and national level (Governor's /County Award) will be developed and this ceremony will be held once a year The 16 focus counties will also be supported to integrate EPI needs within their County Integrated Development Plans. In order to strengthen Joint planning, joint implementation, M&E and joint re-programming a Partners Engagement Framework for EPI will be developed. The counties will then be supported to conduct an annual EPI stakeholders' forum (ICC) In the context of approaching a period of GAVI graduation, financial suitability plans need to be developed. These will be incorporated into the County Integrated development plans and the County Health Strategic Integrated Plans for all 47 counties. This activity will translate into development of tailored solutions for challenges that impact on immunization coverage Equity analysis will provide crucial information on the profile of high risk population groups to inform advocacy at county level for targeted operations. This shall be used to inform immunization advocacy agenda in the counties and enhance planning and implementation landscape thus improving the governance and financial sustainability for immunization outcomes in line with devolution
Activity 1.3: Build capacity of Civil Society Organisations to lobby for immunization within and without the health sector **The following sub-activities will be implemented under this main activity:** Activity 1.3a: Strengthen the already formed CSO county chapters in the focus counties Activity 1.3b: Support the formation and coordination of 11 county CSO chapters in line with devolution.	An information advocacy package will be developed by HENNET. Annual meetings will be conducted by the CSO with the Parliamentarians, the county assembly and community leaders This activity will expand CSO involvement in immunisation both within and outside the health sector. HENNET's capacity for lobbying for immunization will be strengthened so that there will be increased demand for immunization and increased resource allocation for immunization at both county and national levels.

	County chapters are going to play the HENNET advocacy roles at the county levels. They are a network of Health CSOs working at the county. They will engage the county leadership in championing for immunization services by working hand-in-hand with them as well as working as a watchdog to county prioritization of immunization services
Activity 1.4: Conduct high level advocacy and planning meetings with Ministry of Finance, Ministry of Health, Parliamentarians and the 47 County Assemblies **The following sub-activities will be implemented under this main activity** 1.4a Conduct high level advocacy and planning meetings with Ministry of Finance, Ministry of Health, Parliamentarians and the 47 County Assemblies by CSO 1.4b Conduct high level advocacy and planning meetings with Ministry of Finance, Parliamentarians by Ministry of Health	Evidence-based advocacy briefs will be developed through investment case studies, evidence on financial sustainability, county plans and equity coverage data. The evidence generated by the immunization program will be presented at the high level advocacy meetings that will be conducted annually. This activity will bring on board the main players in financial decision making to recognize the current and future requirements for EPI so that they commit to sustainability strategies. It is expected that as a result of this, more resources will be allocated for immunization operations this should translate to equity and improved coverage.
Objective 2: To achieve equitable access to and utilization of routine immunisation services in 16 focus counties by 2019	
Activity 2.1: Conduct demand generation activities that target communities, leaders and caregivers in the 16 focus counties **The following sub-activities will be implemented under this main activity:** Activity 2.1.a: Conduct workshop to adopt National communication plan of action including risk communication in the context of devolution Activity 2.1.b: Conduct workshop to develop County communication plan of action including risk communication for the 16 focus counties. Activity 2.1.c: Develop a Job Aid (Flip chart) for CHVs on immunization in all 47 counties annually Activity 2.1.d: Train Sub-County Social mobilizers biannually as TOTs on IPC in all 16 focus counties Activity 2.1.e: Conduct training for CHVS on IPC for all 16 focus counties. Activity 2.1.f: Conduct consultative meeting for 60 national health journalists on Immunization	This activity aims at systematically addressing current gaps in caregiver knowledge on diseases targeted for immunization, low community risk perception on vaccine preventable diseases, caregiver knowledge on vaccination schedule, emerging vaccine hesitancy and knowledge gap amongst health professionals through various communication and social mobilization strategies (mainly through use of media and Interpersonal communication through frontline health workers, community leaders and other stakeholders). All these factors are contributing to suboptimal immunization coverage in selected population groups. Communities and other stakeholders will be mobilized to reduce dropout rates and create sense of urgency for immunization. Addressing gaps in knowledge, skills and practice amongst frontline health workers through training, support supervision and mentorship will contribute towards improved delivery of quality services, caregiver confidence on the EPI program and reducing/eliminating

Activity 2.1.g: Support all Health facilities in the 16 selected focus counties to hold biannual meetings with community; Activity 2.1.h: Support 3200 CHVs and community leaders linked to the HF in the focus counties to mobilize community/caregivers to increase immunization coverage Activity 2.1.i: Conduct orientation workshop for media personnel in all 16 focus County on Immunization Activity 2.1.j: Development of media messages on immunization annually Activity 2.1.k: Production of media messages on immunization in 18 languages Activity 2.1.l: Airing of media messages on immunization in 25 electronic media outfits annually Activity 2.1.m: Printing of Job Aids on Immunization for CHVs in all 16 focus counties Activity 2.1.n: Conduct bi-annual consultative meetings with leaders from special groups: Kraal leaders of nomadic communities; leaders of religiously hesitant sects in the 16 focus counties Activity 2.1.o: Conduct annual meetings for 30 Health promotion officers in 16 target counties Activity 2.1.p: Conduct annual performance review meeting with all 47 County Health promotion officers Activity 2.1.q: Conduct Bi-annual County Stakeholders meetings for 16 target counties Activity 2.1.r: Printing of immunization certificates for children who have completed their immunization schedule annually Activity 2.1.s: Printing of certificates for best performing CHVs Activity 2.1.t: Support Health Facilities to conduct biannual certificate award ceremonies Activity 2.1.u: Training of CSOs on health-right based approach to the community for demand generation Activity 2.1.v: Support CHVs and CHWs to disseminate immunisation messages leveraging on the community health strategy Activity 2.1.w: Conduct community appraisal on immunisation services and disseminate appraisal reports to inform programming Activity 2.1.x: Setup of Private-Public partnerships at county and sub-county levels to	missed opportunities. The adoption and implementation of REC strategy in the 16 counties will focus on improving the linkage between health facilities and the communities in catchment population, registration of children and households, community mapping of unreached children, development of community and health facility specific micro plans and implementation of strategies aimed at reaching most marginalized population groups like nomads with lifesaving vaccines, tracking defaulters, and monitoring of immunization performance. This is expected to contribute to increased vaccination coverage and reduction of dropout rates. Immunization Certificates will be printed and awarded to children who have completed immunization to create visibility for immunization and the desire amongst caregivers to complete schedule. Kenya has adopted the RMNCH scorecard as a management and accountability tool. The RMNCH scorecard will be adopted for immunization in the 16 focus and national MOH to promote accountability and generate public discussion on performance which will drive action amongst key decision makers and caregivers.

enhance integration of immunisation messages within their programming. Activity 2.1.y: Develop Immunization scorecard using the national and county RMNCAH tool Activity 2.1.z Procurement of 2 vehicles for project support supervision by national	
Activity 2.2: Enhance the knowledge and skills of CHVs, frontline healthcare providers, management teams, professional groups, Expert committees and lecturers through trainings/OJT, and development of knowledge sharing platforms/document repository **The following sub-activities will be implemented under this main activity:** Activity 2.2.a: Conduct annual workshop to Develop EPI technical materials for dissemination to Immunization staff in all 47 Counties Activity 2.2.b: Conduct annual technical consultative meetings with professional associations at national level Activity 2.2.c: Support national EPI technical staff to disseminate immunization related information to 6 professional bodies during conferences and annual general meetings Activity 2.2.d: Support County Directors of Health to disseminate immunization related information to professional associations at county level annual for all 47 counties Activity 2.2.e: Conduct training on IPC for H/W in all 16 focus counties. Activity 2.2.f: Conduct Operational level training for health facilities in 16 focus counties Activity 2.2.g: Conduct MLM training on EPI for CHMTs/SCHMTs in all 16 focus counties Activity 2.2 h: Develop online immunization repository to improve access to EPI resources/materials Activity 2.2.i.: Conduct quarterly sub county support supervision in all 16 focus counties Activity 2.2.j: Conduct biannual national and county support supervision to all 47 Counties Activity 2.2.k: Conduct annual update meeting with lecturers from training institutions on EPI. Activity 2.2.l: Document effect of updated pre-service curriculum on immunization program	Following devolution of health services, there has been a lot of changes in HR availability leading to many vaccinators lacking basic skills in immunization. To address this gap that has contributed to low caregiver perception on quality and confidence in the program, seeks to improve knowledge, skills and practice amongst healthcare providers through Operational level training of frontline health workers including OJT, support supervision and mentorship in the 16 counties. This will contribute to improved delivery of quality services thereby reducing incidences of AEFI and generating caregiver confidence on the EPI program and reducing/eliminating missed opportunities. As long term sustainability drive, implementation of EPI curriculum in training institutions will be assessed to ensure newly graduated professionals acquire the requisite knowledge and skills. It has been noted that the socio-economic middle class rely mostly on opinion of their private doctors for decision on immunization. Most of the professionals in the private sector that are often consulted by these caregivers have not been adequately engaged by the program to update their knowledge on routine immunization. This has led to incidences of refusals by caregivers due to wrong advice not being provided to them. Engaging professional bodies will help bridge this knowledge gap. Missed opportunities for children attending health facilities and outreach services remains a critical challenge. Supporting the use of MoH MNCH integration job aid and chart will contribute towards ensuring children receive all basic MNCH interventions due to them during visit to health facilities and outreaches. Disease surveillance is key to timely detection and response to vaccine preventable disease outbreak. Data provided by surveillance system including quarterly risk analysis also helps immunization program to identify areas of low population immunity/unreached children for action.

(officers drawn from training institutions, licensing bodies and EPI program) Activity 2.2.m: Conduct sensitization meeting for H/W and -Sub County and county on MOH MNCH Integration -job aid and chart in all 16 focus counties Activity 2.2.n.: Launch of AEFI expert review committee- Activity 2.2.o: Induction of AEFI technical expert review committee on causality assessment -one off Activity 2.2.p: Bi yearly meetings of AEFI technical expert review committee Activity 2.2.q: Train 1645 HCWs on vaccine preventable disease surveillance. Activity 2.2.r: Trainings of CHMTs & SCHMTS on IDSR and community based surveillance in 4 counties Activity 2.2.s: Sensitize Community Health Workers(CHWs) on community based Surveillance in 4 counties	
Activity 2.3: Implement county specific REC strategy to reduce the number of unvaccinated children and inequities in the 16 focus counties through joint mapping of unreached children and microplanning with communities, support implementation of strategies in the micro plans to reduce inequity **The following sub-activities will be implemented under this main activity:** Activity 2.3.a: National Review of microplanning templates and guidelines on immunization Activity 2.3.b: Orientation of SCHMTs on microplanning templates in all 16 focus Counties. Activity 2.3.c: Conduct microplanning workshop for all health facilities and community in all 16 focus counties. Activity 2.3.d: Support quarterly immunization outreaches in all 16 focus counties as part of REC.	This activity seeks to support adoption and implementation of the WHO-UNICEF REC strategy the 16 counties focusing on improving linkage between health facilities and communities in catchment population, registration of children and households, community mapping of unreached children, develop community and health facility specific micro plans and strategies to vaccinate these children, implement strategies aimed at reaching most marginalized population groups like nomads, track defaulters, and monitor immunization performance. This expected to increase coverage and reduce dropout rates.
Activity 2.4: Select Immunization Champions /Ambassadors grooming; Support for attending functions within the county (once a quarter)	Immunization champions have been very effective in addressing vaccine hesitancy, creating linkages with communities, confidence building, increasing visibility of immunization program and increasing demand for immunization services. Addressing the above will increase coverage. This has been evident for

	the Polio Eradication Initiative where 13 polio/immunization champions were engaged since 2013. This application intends to scale up their engagement to all 47 counties and provide consistent support for their volunteer work in promoting immunization services. This has the potential of influencing demand for health services.

Objective 3*:* To strengthen immunisation supply chain and logistics system (iSCL) for availability of quality vaccines and immunization supplies at national and subnational levels by 2019	
Activity 3.1: Invest in rehabilitation, expansion and upgrade of the cold chain equipment and accessories to ensure appropriate capacity and quality for existing and new vaccines. **The following activities will be carried out** Activity 3.1.a: Cold Chain Equipment procurement Activity 3.1.b: Cold Chain Logistics procurement and distribution Activity 3.1.c: Support all sub-county Medical engineers to undertake PPM (Planned Preventive Maintenance) (PPM) plan	This will address the inadequate cold chain management systems and infrastructure leading to improved access to immunization therefore reduced morbidity and mortality The cold chain inventory of 2015 showed a requirement of 1168 solar direct drives for facilities with no electricity and 3985 ice lined refrigerators are required for facilities that have electricity or have outdated absorption fridges. With the current HSS grant we aim to procure • 541 TCW 40SDD for HFs without Electricity, and those currently using gas • 836 TCW 40SDD to replace adsorption refrigerators at Health Facilities • 93 MF314 freezers for sub county stores across 14 counties that do not have adequate freezing capacity • Procure 621 MK144 for new immunizing facilities • 923 MK144 to replace the non-EPI refrigerators at Health Facilities • 1937 MK144 to replace adsorption refrigerators at Health Facilities (Total 3,481 MK144 fridges) These fridges will ensure that the 16 focus counties will have adequate cold chain capacity. The equipment will also be distributed to the other counties and the deficit cold chain requirement for the rest of the country will be requested under the Gavi cold chain optimisation fund.

	The procurement of continuous temperature monitoring devices will ensure that vaccine storage temperatures are monitored adequately and hence maintain quality. The Gavi HSS cash support will be utilized in operationalization of cold chain repair and planned maintenance system by ensuring that the trained cold chain technicians carry out preventative maintenance. The county governments will subsequently continue to support the cold chain repair and maintenance system.
Activity 3.2: Expand the stock management system and strengthen HR capacity building to improve end to end stock visibility from national to HF level Activity 3.2.a: Upgrade the stock management tool (SMT) to include cold chain inventory tracking and training on it use. (Costing for Upgrade of SMT software) Activity 3.2.b: Hiring and training of 4 staff for central and regional depot managers in Eldoret and Mombasa (for the regional depots that do not have MoH staff and are currently being supported by KEMSA. At the central stores, 2 supply chain officers will boost the operations as currently there is only one officer manning both the dry store and vaccine stores. Activity 3.2.c: Engage a supply chain strengthening technical assistance to support improved data collection, analysis and system optimization (Consultant for 6 months staggered over the three years) Activity 3.2.d: Carry out training for health facilities on the temperature monitoring and response system to health facilities Activity 3.2.e: Development of an app. (application) for vaccine management to be accessed on android phones /tablets e.g. IMCI Activity 3.2.f: Conduct forecasting review meeting –once a year- Activity 3.2.g: Hold annual Immunization Supply chain workshop Activity 3.2.h: Conduct sensitization workshop for Biomedical engineering lecturers on EPI updates and new technologies	The stock visibility will ensure optimal use of vaccines based consumption leading to fewer missed opportunities and reduced drop out for vaccination. This will lead to increased coverage and reduction in vaccine preventable diseases by administration of potent vaccines. Following devolution, the County Governments are responsible for management of vaccine stocks in the counties. A huge challenge has been in ensuring visibility of stock availability and tracking of consumption, wastage, utilization of vaccines. The stock management tool will help ensure visibility of vaccines at the sub county store level and provide information that will support interventions such as redistribution between counties, interventions to tackle closed vial wastage and supply planning including forecasting and ordering. The stock management system will be housed within the Government servers and infrastructure and will be managed by the Government after the initial development and roll using of the tool using the Gavi HSS funds. The stock management system will integrate cold chain and temperature monitoring and alerts system together with the vaccine supplies. The Gavi HSS funds will also be used to increase the skills and knowledge of new county and sub county managers, cold chain medical engineering technicians and other staff in vaccine and cold chain management procedures.

Activity 3.2.i: Carry out a rapid assessment on vaccine management practices at health facilities in selected counties and action plan	
Activity 3.3: Strengthen transport logistics and equipment functionality to ensure vaccine availability and quality Activity 3.3. Vehicle and boat procurement	By addressing the last mile of the supply chain, regular supply of vaccines will lead to fewer missed opportunities and reduced drop out for vaccination. The Gavi HSS funds will be utilized in procuring 12 vehicles and 2 boats for 14 counties that have transport challenges and island counties (Lamu and Homabay). These counties were selected due to the vastness of the county, distances between the sub county stores and regional stores, facilities and sub county stores and poor public transport network cutting of facilities from supplies and support. The vehicles and boats that will be procured for these counties will be used in vaccine distribution, transporting supervisors to the facilities for OJT and support supervision and will offer support in ensuring cold chain response system to breakdowns such as rescuing vaccines and transporting vaccines to a nearby functional fridge are carried out. The vehicles will be maintained and managed using the county funds and procedures will be in place to ensure that the vehicles are used in supporting the immunization system. A refrigerated truck would be used to transport vaccines from the regional stores that serve far flung counties targeted in this proposal as the out-sourced provider delivers up to the regional stores. The vehicle will also be used to undertake inter-county redistribution of vaccines to mitigate stock-outs. All counties will be provided with motorbikes to support medical engineers undertake preventive maintenance activities and repair of broken down equipment. This will help reduce the equipment downtime and in turn assure vaccine quality and reduce stock-outs related to equipment breakdown
Objective 4: To strengthen immunisation data management and information systems for timely decision making at national and subnational level by 2019	
Activity 4.1: Strengthen data quality procedures for routine immunization and gender equity	This activity will address overall data management framework, provide linkage of coverage data with vaccine utilization as a way

In order to strengthen data quality procedures, the following tasks will be carried out: Activity 4.1.a: Develop an operational M&E Plan to provide overall data management framework Activity 4.1.b: Develop interface to link coverage data with vaccine utilization; Activity 4.1.c: Conduct data quality self-assessment Activity 4.1.d: Pilot electronic registers at HF level in two counties; Activity 4.1.e: Use community volunteers for house mapping to collect data on children under 1 year and immunization status	of enhancing monitoring, capacity for data validation and target setting for improved accuracy in Routine Immunization indicators. An interface and operating protocols in use of the vaccine utilization and coverage data will address identified gaps in coverage data and vaccine utilization. Data quality self-assessment will be implemented and data quality improvement plans will be developed with resultant improvements in data quality. Piloting of electronic platform in the pilot areas will provide an opportunity to innovate and utilize technology for data collection which will generate gender disaggregated data that will highlight potential inequity in access to immunisation so that it can be addressed resulting in improvement in coverage.
Activity 4.2: Enhance the capacity (knowledge, skills and practice) of Healthcare providers and managers at national and counties in immunization Data management including analysis and use for decision making **Specific tasks will include:** Activity 4.2.a: Train healthcare workers and managers on DQS Activity 4.2.b: Immunization and Disease surveillance technical assistance/ field verification visits to Counties to be done on quarterly basis. Activity 4.2.c: Enhance the capacity (knowledge, skills and practice) of Healthcare providers and managers at national and counties in immunization Data management including analysis and use for decision making; Training in analysis (M&E) Activity 4.2.d: Support supervision - Conduct Annual Support supervision by national staff to HF/Sub-County; Conduct bi-annual Support supervision by County staff to HF/Sub-County	This activity will build capacity of health workers and data managers for generation of quality data, continuous data analysis and indicator monitoring thereby ensuring the availability of reliable and representative data for evidence based decision-making in EPI. This will also provide opportunities for targeted support supervision depending on the gaps that are identified. Trained health workers and data managers will result to improved quality of data and its use with resultant increase in coverage of most vaccines.
Activity 4.3: Evaluate the performance of the immunization program and HSS grant in achieving the desired immunization outcomes Specific tasks that will be carried out include: Activity 4.3a: Conduct immunization performance review and feedback at national and county level to improve coordination;	This activity will help monitor progress in coverage, identify existing inequities and challenges within the EPI programme. Assessment of performance will include reviewing of action plans and Gavi HSS related plans. Furthermore, immunization reports/bulletins will be produced from counties and national levels. Coverage survey will provide

Activity 4.3.b: Undertake coverage survey to identify existing inequities and challenges within the immunisation program; Coverage survey will be contacted in 47 counties using census house cluster of 30 respondents per county total 1320 cluster targeting approx.76,000 households Activity 4.3.c: Conduct an in-depth external EPI review Activity 4.3.d. Conduct end of Gavi HSS grant evaluation	an in-depth understanding of bottlenecks and inequities that exist in accessing and utilizing immunization services which will inform programming.

14. Results chain *(Maximum 4 pages)*

*Complete the **Results Chain** using the template provided below. For each objective defined in Question 12, provide information on: (i) activities (as noted in Question 13); (ii) intermediate results; (iii) immunisation outcomes; (iv) impact; and (v) assumptions for the achievement of results.*

*Once the Results Chain has been developed, the next step is to complete the **Performance Framework** (for all HSS applications i.e. including for applications for pooled fund support). This can be accessed through the Gavi country portal: www.gavi.org*

***Pooled fund** applicants are not required to complete this template, but must provide a summary of how Gavi HSS funds will contribute to improve immunisation outcomes in the context of the NHSP*

Results chain			
***Objective 1*: ➔ To accelerate strong political engagement, improve governance and financial sustainability for immunization outcomes in line with devolution by 2019**			
Key Activities: 1.1 Develop an operational Declaration (or MOU) clarifying roles and responsibilities between national and county levels 1.2 Build capacity of technical and policy makers to understand and address EPI health sector constraints 1.3 Build capacity of Civil Society Organisations to lobby for immunization within and without the health sector 1.4 Conduct high level advocacy and planning meetings with Ministry of Finance, Ministry of Health, Parliamentarians and the 47 County Assemblies	→	**Intermediate Results:** 1 National and 47 county governments are clear on their roles and responsibilities as regards management of EPI services in a devolved system 2 Each of the 16 focus counties have at least 1 CSOs actively engaged in EPI related activities 3 Sufficient funds for immunization at national and county level	→ **Immunisation Outcomes:** 1. At least 80% of sub-counties report more than 80% Pentavalent (DPT3) coverage by 2018/19 2. % of surviving infants receiving 3 doses of DTP-containing vaccine 3. % of surviving infants receiving first dose of measles containing vaccine 4. Difference in DTP3 coverage between lowest and highest wealth quintile 5. % point drop out between DTP1 and DTP3 coverage
Related Key Activities Indicators: 1.1 Operational Declaration or MOU describing role and responsibilities for EPI at county and national levels 1.2 Number of Technical and policy makers equipped with skills to address local health sector constraints 1.3 Number of Civil Society Organizations trained to advocate for immunization within health and non-health sector partners and community leadership 1.4 Number of Bi-annual high level advocacy and planning meetings held with Ministry of Finance, Ministry of Health, Parliamentarians and the County Assemblies		**Related Intermediate Results Indicators:** 1 Proportion of the 47 counties with Immunization improvement plans 2 Proportion of 16 focus counties with at least I CSO involved in immunization mobilization per 3 Proportion of 47 counties reporting zero stock out of injection devices 4 Timely fulfilment of co-financing commitment for all Gavi-supported vaccines	
***Objective 2:* ➔ To achieve equitable access to and utilization of routine immunisation services in 16 focus counties by 2019**			

Key Activities:

Activity 2.1: Conduct demand generation activities that target communities, leaders and caregivers in the 16 focus counties
Activity 2.2: Enhance the knowledge and skills of CHVs, frontline healthcare providers, management teams, professional groups, Expert committees and lecturers through trainings/OJT, and development of knowledge sharing platforms/document repository.
Activity 2.3: Implement county specific REC strategy to reduce the number of unvaccinated children and inequities in the 16 focus counties through joint mapping of unreached children and microplanning with communities, support implementation of strategies in the micro plans to reduce inequity.
Activity 2.4: Select Immunization Champions /Ambassadors grooming; Support for attending functions within the county (once a quarter)

Related Key Activities Indicators:

1 Number of community meetings on immunization held

2 Number of frontline healthcare workers (HPOs, CHVs, CHEWs, CHC) trained in IPC for immunization.

3 Proportion (%) of sub-counties with communication plans of action

4 Proportion (%) of immunizing health facilities with at least 1 vaccinator trained on EPI

5 No of immunization champions engage**d**

Intermediate Results:

1 Caregivers in the 16 focus counties are aware of and adhere to the national immunization schedule

2 Health-workers adhere to immunization guidelines including reporting on AEFIs

3 All health facilities in target counties implementing micro plans to reduce numbers of unvaccinated children

4 Difference in average DPT 3 Coverage in the 16 focus county and National is reduced

Related Intermediate Results Indicators:

1 Proportion (%) of caregivers able to recall immunization schedules at exit interviews

2 Proportion (%) of caregivers adhering to current immunization schedule

3 Proportion (%) of healthcare providers delivering immunization services adhering to the immunization guidelines

4 Proportion (%) of health facilities with micro plans

5 Proportion (%) of planned outreaches that have been implemented

6 Number of unvaccinated children by ward in the 16 focus counties using MCV1

Immunisation Outcomes:

1. In the 16 focus counties,

a. At least 80% of sub-counties in the focus 16 counties report more than 80% Pentavalent (DPT3) coverage

b. Fully immunized child (FIC) increased to at least 90%

c. % drop out rate (Penta 1-Penta 3) reduced to less than 5.6

2. National Difference in DPT3 coverage between the lowest and highest wealth quintile reduced

	7 Total Number of unvaccinated children in the 16 focus counties using MCV1 8 Percentage point difference in average coverage (DPT3) between the 16 focus counties and National 9 Number of focus counties within less than 10% DPT3 coverage difference with national level	
Objective 3: ➔ **To strengthen immunisation supply chain and logistics system (iSCL) for availability of quality vaccines and immunization supplies at national and subnational levels by 2019**		
Key Activities: 3.1 Invest in rehabilitation and expansion of the cold chain equipment and accessories to ensure appropriate capacity and quality for existing and new vaccines in underserved regions 3.2 Expand the stock management system and strengthen HR capacity building to improve end to end stock visibility from national to sub-county level 3.3 Strengthen transport logistics and equipment functionality to ensure vaccine availability and quality through procurement of vehicles, boats and motorcycles	**Intermediate Results:** 1 80% of immunizing health facilities have functional cold chain equipment 2 Reduction in damage and wastage of vaccines through freeze and heat excursions 3 Down time for cold chain equipment in the 16 focus counties reduced to less than 1month 4 All sub counties report on stock management using the national SMT 5 Zero HF stock outs of nationally available vaccines 6 National and county logistic staff have adequate competencies in ISCM	**Immunisation Outcomes:** 1 At least 80% of sub-counties in the 47 counties report more than 80% Pentavalent (DPT3) coverage 2 % of surviving infants receiving 3 doses of DTP-containing vaccine 3 % of surviving infants receiving first dose of measles containing vaccine 4 % point drop out between DTP1 and DTP3 coverage 5 National Fully immunized child (FIC) increased to 90%
Related Key Activities Indicators: 1 Number of health facilities in the 47 counties that have been supplied with new cold chain equipment 2 Number of sub-counties in the 47 counties that are using national SMT to monitor end to end vaccine stock level	**Related Intermediate Results Indicators:** 1 proportion of immunizing HF with functional cold chain equipment 2 Incidence of heat and freeze excursions	

3 Number of counties provided with means of transport for Medical Engineering Technologists and Logisticians 4 Number and proportion of logistics staff trained in immunization supply chain management	3 Average downtime for cold chain equipment requiring repairs in the 16 focus counties 4 Sub-counties reporting rate using national SMT 5 proportion of immunizing HF in the 47 counties reporting zero stock outs for nationally available vaccines 6 Number and proportion of logistics staff trained in immunization supply chain management that meet the minimum competency required	
Objective 4: **➔To strengthen immunisation data management and information systems for timely decision making at national and subnational level by 2019**		
Key Activities: 4.1 Strengthen data quality procedures for routine immunization and gender equity 4.2 Enhance the knowledge, skills and practice of Healthcare providers and managers at national and counties in immunization data management including analysis and use for decision making 4.3 Evaluate the performance of the immunization program and HSS grant in achieving the desired immunization outcomes	**Intermediate Results:** 1 Improved data quality assessment scores in 16 counties 2 Regular National and sub-national performance reviews conducted 3 Quarterly immunization bulletin that highlight existing inequities available in the 16 focus counties	**Immunisation Outcomes:** 1 At least 80% of sub-counties report more than 80% Pentavalent (DPT3) coverage 2 Fully immunized child (FIC) increased to 90% 3 % drop out rate (Penta 1-Penta 3) reduced 4 National Difference in DPT3 coverage between the lowest and highest wealth quintile reduced
Related Key Activities Indicators: 1. Number of counties amongst the 16 focus counties that have conducted DQS	**Related Intermediate Results Indicators:** 1 Proportion of counties c reporting improvement in data quality scores	

2. Number of counties in the 16 focus counties with complete household register of children 3. Number of health workers trained on data management 4. Proportion of planned immunization performance reviews conducted	2 Proportion of health facilities in the 47 counties reporting in DHIS Proportion of the 16 counties with updated household registers 3 Proportion of counties disseminating quarterly immunization bulletin	

IMPACT

Provide an impact statement and indicator(s):

The implementation of this grant will contribute to the reduction in infant and under-five mortality morbidity and mortality rates in line with the Vision 2030 by 2019.

ASSUMPTIONS

1) Political buy in at county and national levels for the intended change
2) Timely financing for routine vaccines; Equitable retention of EPI trained staff by Counties during the program period
3) Security situation in the country maintained or improved.
4) Timely availability of HSS grant funds
5) Minimal or no disruption of County health services due to weak HR management.
6) Equitable distribution for HR for health

15. Monitoring and Evaluation (M&E) *(Maximum 2 pages)*

Provide a description of how HSS grant performance will be monitored. (i) Provide details on how monitoring activities will be undertaken, including how data collection, analysis and synthesis, as well as communication and use of data will be carried out for the HSS grant. (ii) *Provide details on how evaluation activities will be undertaken, including when the end of grant evaluation will take place and whether a mid-term evaluation is planned.*

Gavi HSS grant will be monitored at two fronts namely:

1. Technical monitoring
2. Financial monitoring

Technical monitoring

Technical monitoring will be carried out monthly, quarterly and annually. The tracking process will focus on input, process and outcome indicators. The results chain has generated a set of activity indicators, intermediate and outcome indicators that will be used to monitor progress for each objective. A set of intermediate results and outcome indicators have been incorporate in the performance framework. The selection of the indicators included in the performance framework online template is considered the magnitude of funding – with the activities with the bulk of funding used as a tracer for the other activities. Other considerations for inclusion of the indicators in the performance include the sensitivity and representativeness in measuring the desired result. These indicators are described for each objective with regard to a mix of actual activities in the results chain and intermediate results. Procurement of costly items such as vehicles and cold chain equipment will be tracked as part of the financial tracking.

Data to measure these indicators will be collected using the existing routine health information system (HIS). For those intermediate results that do not exist in HIS, rapid assessments and surveys will be used to collect the data. The information generated will be shared with Ministry of Health management as well as presented during the ICC/HSCC meetings as part of the wider update on the implementation of Gavi grant

Periodic evaluations will be carried out during the grant period. A coverage survey will be undertaken after one year of implementation and will provide evidence for program adjustment. In addition, annual Joint Appraisal will be conducted to assess grant performance.

Financial monitoring

The process of receipt and accountability of funds is described in the implementation arrangements (section 19). Specific to grant monitoring, funds allocated will be tracked on the basis of amounts, timing and retirement of accountability at the level of activity implementation. This process will be tracked on a quarterly basis with records being maintained at source and at the Project Implementation Unit. All financial transactions will be subjected to regular internal and external audit processes.

At the end of HSS grant period, an end term evaluation will be undertaken to document the best-practices and implementation challenges as well as to determine the impact of the grant. End of grant evaluation will employ a combination of various methodologies e.g. desk review of existing documentation, key informant interviews, Focus group discussions, exist interviews, field visits and survey.

16. PBF Data verification option	
Choose which data verification option to be used for calculating the performance payments.	
Data verification option	**Select ONE**
Use of country administrative data	V
Use of WHO/ UNICEF estimates	
Use of surveys	

PART D: WORKPLAN, BUDGET AND GAP ANALYSIS

17. Detailed workplan, budget narrative and gap analysis *(Maximum 3 pages)*

*Complete **Mandatory Attachment #6: Detailed workplan, budget and gap analysis,** which can be accessed at the online country portal.*

Detailed instructions to fill in the budget template are available in the first worksheet of the Excel template.

*Once the budget template and financial gap analysis has been completed, provide a **budget and gap analysis narrative** here.*

The development of the budget and the gap analysis was done through an iterative process with involvement of all stakeholders. Under the current HSS budget the country is applying for a total of 20,224,608 from Gavi over a 3-year period. The First year of implementation The country will be requesting for 7814967 which is 38% of the total budget and next 2 years the country will be requesting for 31% of the budget which amounts to 6228403 and 6181239 for year 2 and year 3 of the grant.

In the first year of the grant 42% and 49% of the budget will be used for objective 2 and Objective 3 respectively. The majority of cold chain procurements and set up activities will be done in the first year of the grant. The second year of the grant there will be scaling up of objective 2 activities and the activities will account for 65% of the total grant for year 2 and year 3 activities.

11.7% of the total grant2 will be used for objective 4 which includes monitoring and evaluation activities

There is a standard 3% of the grant that will be used over the 3 years in program management for the grant by the CSO and the Government of Kenya. The funds allocated to program management by the Government of Kenya do not include salaries or salary top up and only includes costs for implementation of supervision, fuel for supervision and office equipment and communication cost. The CSO program management budget includes the staff time for individuals who will be hired to support the management of the grant as well and other office costs and program costs.

There will be 4 lead implementers of the grant. The Ministry of Health will be the primary Implementer and will carrying out activities to a total of USD 12,817,667 which is 63.4% of the budget.

The other implementing partners are HENNET (CSO) who will be responsible for 17.1% of the budget that totals to 3,466,940, WHO 5.4% of the budget to a tune of 1,261,763 and UNICEF which will be responsible for 13.2% of the budget which is 2,678,238. The Government will be implementing activities in all the objective areas. HENNET will mainly be implementing activities in objective 1 and objective 2. WHO is mainly responsible for the coverage survey which is objective 4. UNICEF will be carrying out activities in Objective 2 and Objective 3 and the biggest activity is the procurement of cold chain equipment in objective 3.

Technical assistance has been requested for WHO and UNICEF as per activities listed in the procurement plan and budget

The gap analysis was carried out in a collaborative manner between all stakeholders involved in health. The total requirement was done by determining the national and county activities that would be required to meet the targets of the different objectives. Partners provided information of support offered under the different objective areas. The response received however was difficult to separate support by the objective areas as a lot of support offered by several partners is general to Maternal, Neonatal and Child Health(MNCH) and immunization support is only a small component of the support and of the immunization support offered it is difficult to break down into our objective area.

The total requirement for funding for the 4 objectives areas is estimated to be USD 75,929,439. Objective 1 requirement is 3,755,375(5% of total), Objective 2 requirement is 55,043,780(72% of total), Objective 3 is 14,689,553(19% of total) and Objective 4 requirement is 2,440,732(3% of total). This is the total estimated requirement for carrying out the 4 objective areas in the country and not the total cost of carrying out immunization services.

The available funds by the objective areas are available for the technical partners who support immunization services. The total available funds are USD 1,433,178 which is available from UNICEF, WHO, CHAI, USAID- MCSP, and HENNET. The other funding available to immunization is not available by the objective areas because it is part of larger MNCH funding. The current funding does not reflect support that has been completed such as the KFW support for cold chain and JICA support for cold chain. The gap analysis does not reflect funding that may support the immunization program but has not been confirmed and the total funding to immunization is not available such as the World Bank's Global Financing Facility(GFF).

Pooled fund *applicants are not required to complete the workplan, budget and gap analysis template. Instead, specific information on the sector wide annual workplan and budget should be provided.*

18. Sustainability *(Maximum 2 pages)*

Describe how the government is going to ensure programmatic sustainability of the results achieved by the Gavi grant after its completion.

Describe how the government is going to ensure financial sustainability of the results achieved by the Gavi grant after its completion.

If the country requests recurrent activities, describe steps to reduce further reliance on Gavi funding for recurrent costs.

Provide a summary of the country's policy and approach to sustainability.

This GAVI HSS proposal was designed, from inception, with sustainability as part of the design. The design utilizes existing structures and systems within MOH in the implementation of the programme. It took into consideration various parameters of sustainability:

- **Political:** Political goodwill exists in Kenya to advance the right to health for all citizens with RMNCH identified as a priority area of investment by National and county governments. Devolution has provided opportunity for increased ownership of health services by communities, which will lead to increased investments and accountability by health system. Current expansion of access to services especially in the underdeveloped regions targeted by this proposal will sustain the gains made through this proposal. The health bill is being debated in parliament and when enacted into law will ensure sustained commitment by all stakeholders including the National and County governments, partners and community members. By developing participatory county-level Immunization plans based on partnerships that clarify operational roles and responsibilities in immunization of the different levels within a devolved state will build strategic partnership for expanding the reach of actions as well as for additionality and complementarity of funding.
- **Financial**: There were substantial increases in MOH budget allocations in a nominal term between FYs 2013/14 and 2014/15 from Kshs 36 billion in FY 2013/14 to Kshs 47 billion in FY 2014/15, an increase of 31%. In the same period, counties increased their health budget allocation from 13% to 21% of the total county budget. This trend indicates that the country's commitment to fund health hence high likelihood of continuity of the GAVI supported activities. The graph below shows health budget allocation in the 16 focus counties in the Financial Years 2013/14 and 2014/15

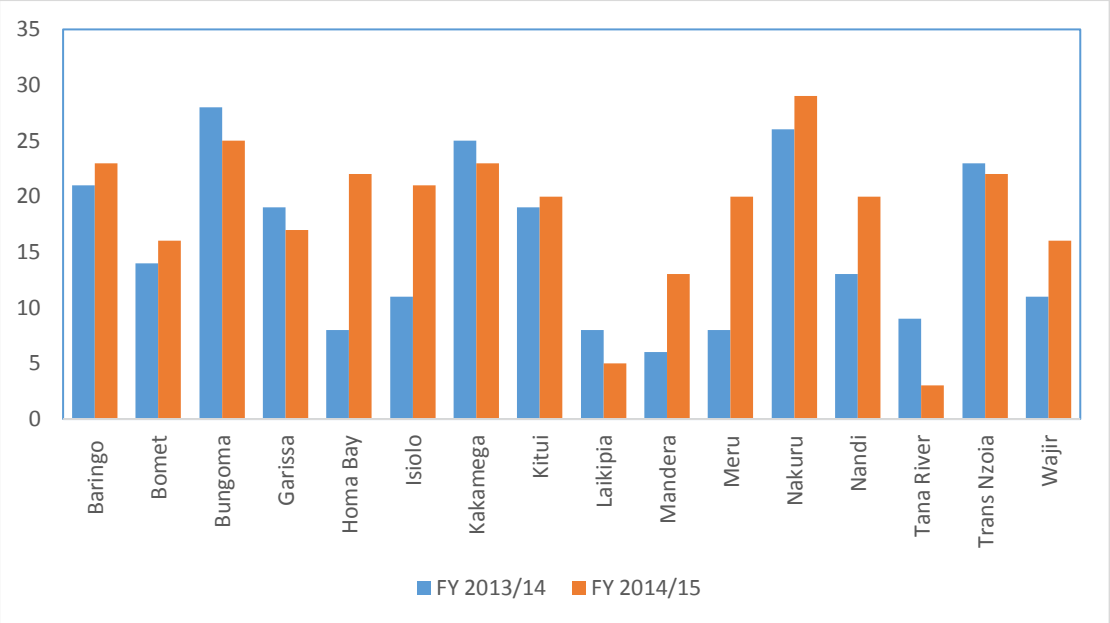


Figure 1. County Percentage Allocation to health FY2013/14 and FY2014/2015 in the 16 focus counties

- It is expected that this will continue by putting in place mechanisms that ensure National and County governmental contribution and buy-in including funding EPI operations. In 2015, the EPI conducted the County stakeholders' forum where county officials responsible for healthy policy and financing were involved. This is planned to be a yearly forum where implementation of immunization programme is discussed and it is expected to translate to increase funding for the programme.
- The Government, through the Kenya Health Policy (2012-2030) intends to design harmonized and progressive resource mobilization strategies targeting all sources of funds, both domestic and international through Global Financing Facility. Furthermore, the Government has committed to open specific budget lines for

maintenance of infrastructure, equipment and transport at national and county levels and to invest in the establishment of maintenance units at county level (section 1.4 of KHSSP 2014-2018)

- Improving physical access to immunization services is key in ensuring sustainability. There is evidence that county governments in regions that have suffered many years of under development and are the focus of this proposal are opening or building new HF including hiring of additional staff. This progressive effort by the County governments to serve over 95% of the population within a 5-kilometer radius in every sub-county with further contribute to sustaining delivery of activities under this proposal.

- The counties will be in charge of motor vehicles, boats and motorcycles. They will ensure maintenance of the motorcycles, boats and vehicles assigned to them. Maintenance of equipment allocated to counties will be done by the county with support from national.

- **Technical:** Since the implementation of the activities will be coordinated by the EPI manager, there will be continuity of the gains made as a result of the HSS grant. Lessons from pilots and 16 focus counties and expanded and scaled up to other counties. Putting in place an **Online Repository** learning systems will provide an opportunity for professional continuous education, training of critical mass of health workers and managers at National and sub national level. There exists an immunization technical working group at national level that will help guide the implementation of interventions beyond the grant

- **Managerial**: Management gains will be sustained by (i). Strengthening government-CSO joint action and funding; (ii). Strengthening the Immunization Technical Work Group through better coordination of the technical partners at national level and implementing partners at the county and sub –county level. (iii)Investing in expanding and increasing the quality of supportive supervision (iv). Strengthening the managerial capabilities of HENNET as they decentralize and build capacity of local chapters, (v) absorbing the warehouse managers by the national Ministry of Health.
- There are currently on-going efforts that will support sustainability through increased investment and accountability in the health sector such as: training in leadership and management;, development of strategic documents that will improve the capacity of the sector to negotiate for additional resources such as: the human resources strategy, cold chain plan, accountability scorecard, evidence and human rights-based planning, investments in pre-service training curriculum for healthcare providers. Leadership and management have been the weakest links in the system and improved capacity in this area will ensure resources within the sector are better managed for results.

- **Social capital**: by facilitating coalition-building and public-private partnerships that place equity, social determinants of health and rights-based approaches at the center of the analysis and the response in line with WHO-UNICEF RED/REC strategy. Involvement of CSO will provide continuous advocacy with both levels of government as well as the communities to prioritize immunization.
- Ensuring a functional public-private partnership. Historically, there have been partnerships between government and non-profit private facilities (Faith Based Organizations) that manage over 50% of all health facilities. The HSS funds will also be used to strengthen health systems within Faith Based Organizations through the CSO component.

- A strengthened health information system and improved district health information system (DHIS2) will assist National and county health systems generate reliable data that will be used for proper planning; effective planning is key to sustainability.
- The proposal design utilizes existing structures and systems within MOH in the implementation of the programme.
- There are currently on-going efforts that will support sustainability through increased investment and accountability in the health sector such as: training in leadership and management;, development of strategic documents that will improve the capacity of the sector to negotiate for additional resources such as: the human resources strategy, cold chain plan, accountability scorecard, evidence and human rights-based planning, investments in pre-service training curriculum for healthcare providers. Leadership and management have been the weakest links in the system and improved capacity in this area will ensure resources within the sector are better managed for results.

***Pooled fund** applicants are required to provide existing documentation that addresses sustainability. List which documents have been provided and reference the relevant sections.*

PART E: IMPLEMENTATION ARRANGEMENTS AND RISK MITIGATION

19. Implementation arrangements *(Maximum 2 pages)*

D*escribe the planned implementation arrangements*

The principal recipient of GAVI HSS grant will be the national treasury (Ministry of Finance). This is the institution by the constitution of Kenya to receive all public funds on behalf of the government. The principal Secretary National Treasury is the government of Kenya principal accounting officer for all the funds which includes donor funds.

The donor funds will be received by National Treasury through Central Bank of Kenya in the respective donor offshore account. The funds upon request by Ministry of Health are transferred through the exchequer system. This arrangement is subject to recommendations by the GAVI Program Capacity Assessment.

The Principal Secretary, MOH with support from the Director Medical Services will be responsible for managing the implementation of the GAVI HSS support. The Unit of Vaccines and Immunization Services (UVIS) will coordinate technical grant functions and activities. The administrative department will provide project implementation support services including: Procurement, finance, human resource, ICT and accounting. Further technical support shall be provided by other relevant technical units within the Ministry of Health and the CSOs. A Project Management Unit (PMU) will be established for day to day management of the grant. It will be composed of a project coordinator, an accountant, M&E officer and supplies and logistics officer. These officers will be MoH employees, deployed by the Principal Secretary (PS) to manage GAVI HSS grant (See attachment 44 – GAVI HSS grant management structure).

Both the HSCC and ICC will monitor progress in implementation of GAVI support for both MoH and CSOs. In addition, the HSCC will provide oversight role and facilitate expediting legal formalities while the ICC will provide technical expertise and monitor the progress from time to time. ICC will approve plans to be implemented using GAVI HSS grant.

The Cabinet Secretary Ministry of Health who is the chief executive officer (CEO) shall provide oversight in the implementation of the GAVI supported HSS.

The principal secretary Ministry of Health who is the accounting officer shall Provide leadership and coordination in the implementation of GAVI HSS.

The Director Medical Services shall provide technical guidance and ensure that the project achieves the desired objectives.

The head of the account unit shall be responsible for processing all the project transactions as provided for the Public Financial Management (PFM) act 2012 and letter of understanding (LOU). The officer will also be maintenance and safe custody of the entire project accounting records and prepare for audits.

The head of the procurement unit will be in charge of the project procurement processes as provided for by the procurement and disposal act of 2009 and letter of understanding. Procurement of cold chain equipment shall be done through UNICEF.

WHO and UNICEF will be funded directly by GAVI for activities allocated to them

Technical assistance will be provided by a number of agencies including- CHAI, USAID/MCSP, JSI, UNICEF and WHO.

Ministry of Health will disburse funds to the county based on a work plan. The County Chief Officer of Health shall be responsible for all financial accountability for funds allocated to the county. The County Director of Health (CDH) shall be responsible for technical implementation of project activities within their counties. County financial and technical reports shall be sent by the Chief Officer to the Principal Secretary, Ministry of Health or their delegated authorities.

Through their representation at the HSCC, ICC and HSS core management team; the CSOs will participate in governance and implementation of the project alongside MOH. HENNET will coordinate the member CSO in terms of operations and reporting of implementation.

Implementation arrangements for CSOs

The GAVI HSS CSOs' grant allocation will flow direct from GAVI to HENNET. The Ministry of Health shall approve the HENNET HSS grant work plan and budgets prior to funds disbursement. The funds shall be disbursed to HENNET annually through electronic funds transfer. The implementing CSOs shall be sub-granted and the funds will be disbursed to the CSOs on a quarterly basis. This fund disbursement arrangement will be dependent on the recommendations from the program capacity assessment to be conducted by GAVI.

HENNET will ensure each of the priority counties has at least one CSO integrating immunization services. To bring the CSOs on board, HENNET will put in an advert on the newspaper with minimum institutional and programmatic standards to be met. The selection team composed of MoH officials, HENNET staff, CRS staff and other stakeholders will choose three CSOs per county in the order of priority. The three organizations selected will then be capacity assessed using the Organizational Capacity Assessment tool (OCAT).

Once the organizational capacity assessment process will be complete, the best organizations will be informed and those not qualifying will also be informed. HENNET will later sign a one-year renewable contract with the CSOs in each of the 16 counties.

HENNET will be able to submit annual work plan and budget to the ministry of health once it has been approved by the HENNET Board of Directors. Subsequently, CSOs will also submit annual work plans and budgets earlier in advance for review by the platform. The work plan and budget will form a basis for funds disbursement to the platform and subsequently to the CSOs. HENNET will carry out monthly financial and programmatic monitoring. All financial obligations undertaken will be aligned to the HENNET finance manual and the GoK finance guidelines. HENNET will receive monthly financial reports from the CSOs. The reports will be consolidated and reported to government, Ministry of Health on a quarterly basis.

HENNET will report jointly with the MoH Unit of vaccines to the ICC and the HSCC on the progress of the grant and further approval of work plans and budgets. The platform will work closely with the Program Management Unit (PMU) to agree on certain cross cutting activities and prioritization of CSOs and MOH activities so as to create synergy and illustrate value for money.

***Pooled fund** applicants are required to provide documentation of the implementation arrangements of the sector wide mechanism, if appropriate. List which documents have been provided and reference the relevant sections.*

20. Involvement of Civil Society Organisations (CSOs) *(Maximum 2 pages)*

Describe how CSOs will be involved in the implementation of the HSS grant.

HENNET is a network of 98 Health Civil Society Organizations (CSOs) in all the 47 counties in Kenya. Over 60% of HENNET members work with marginalized populations, in Arid and Semi-Arid areas, areas facing civil conflict of various forms and refugee camps. The majority of CSOs have a focus in HIV/AIDS, Water, Sanitation and Hygiene (WASH), Malaria, Reproductive Health and Nutrition, vaccination, Gender Based Violence (GBV), Maternal and Child Health (MCH), Tuberculosis (TB).

As much as CSOs have invested heavily in other health interventions, not as much work has been done on immunization and vaccination. Few CSOs such as KANCO, Catholic Relief Services and CHAK have been players in the immunization field. CHAK has worked extensively in the northern and North Eastern parts of Kenya, a region majorly inhabited by mobile populations and greatly affected by cattle rustling. They have been doing outreaches and targeted immunization activities, where they would know at what point the mobile populations would be camping at certain locations and wait for at the location and offer immunization services. This kind of efforts by CSOs has supported in increasing coverage and advancing equity.

Through the HSS grant, CSO sector will be coordinated and strengthened to complement the government efforts in scaling up immunization coverage. This will be achieved by strengthening the already existing CSOs county chapters in the 16 focus counties (5 have existing chapters) and also facilitate the formation and coordination of the remaining (11) county chapters in line with the devolved government structures. Through the CSOs network, HENNET will be able to map out locations with unvaccinated children in the selected sub counties and establish reasons for non-vaccination while mobilizing the communities for immunization. The CSOs at the devolved governments will be strengthened through advocacy sensitization forums where their skills will be sharpened on how to articulate advocacy agenda and engage county leadership, in order to ensure consultative and participatory implementation through all-inclusive participation in all the health decision-making forums in the counties. This will in turn ensure a system-wide spirit at all levels and the alignment of CSO support to the county and national framework. HENNET will mobilize, sensitize and support CSOs involvement in the joint development of County & sub County Annual work plans (AWPs) as well as support the health teams in implementing accelerated routine immunization strategies especially Reach Every Child (REC).

HENNET shall further engage Parliamentarians at national level and the county assembly to advocate for immunization policies and implementation of the same across all the priority counties. Through targeted and evidence-based advocacy and lobbying, the CSOs will ensure that resource allocation, planning and program implementation at the National and at the County levels take into consideration immunization priorities.

CSOs play a significant role in keeping the government and other partners accountable to ensure that commitments and responsibilities to the citizens are fulfilled. The CSOs will develop and implement context/ County specific advocacy strategies to address the diverse needs of the different regions. HENNET through CSOs will empower the communities to appreciate health as a right in line with the provisions of the Kenyan constitution. This will be achieved by supporting CSOs to achieve sustained dialogue with communities and CORPS.

Identified Immunization champions in the selected sub counties will be engaged by HENNET to advocate for immunization. Focus will be on special populations' especially religious leaders, sect leaders and hesitant groups. The use of radio, TV and print media for such advocacy activities will be used both for the local level and national level advocacy. Local media personnel will be trained and oriented on how to report correctly on immunization. HENNET will also undertake operations research to generate evidence for advocacy and to inform the immunization planning and implementation landscape.

The communities will be strengthened and better equipped with the skills to advocate for health as a right. HENNET will develop curricula for training on rights-based approaches to programming and train its member CSOs that will in turn use this framework to plan their actions together with the health facilities and communities. As a way of enlightening the communities, HENNET will focus its efforts to conduct consultative meetings with leaders from special groups; religious leaders, hesitant groups and sects on immunization and benefits of vaccination. Male household heads not only support with financial requirements to have children vaccinated, they also influence the decision to take and complete the immunization schedule. HENNET shall therefore target male involvement in immunization in the selected sub counties.

HENNET will undertake mapping and strengthening of referral networks and mechanisms for adequate response as CSOs establish social accountability systems that support in monitoring the reach of the immunization services. This will be achieved by developing national communication strategy on social accountability and orienting all CSOs in the selected sub counties.

Under this grant, the CSOs will play a leading role in behavior change communication through the use of diverse BCC strategies to reach the remote and vulnerable populations. The CSOs will support health days, immunization week mobilization, health education and service provision to scale up access to and uptake of immunization. HENNET will orient and build the capacity of its members on the REC strategy to immunization with the aim of an eventual cascade to the communities. The CSOs will also lead community appraisal on immunization services and disseminate appraisal reports to inform programming. To increase the level of sustainability and ownership, HENNET will create public private partnerships at county and sub-county levels to encourage other non-health players to integrate immunization within their programming, service and goods delivery.

HENNET's role is pivotal since it will ensure not only a more active involvement of its member CSOs but will also serve to reach to other non-HENNET members that could be strategically placed at the sub county/county levels that could help expand immunization coverage. This could include health and non-health CSOs like NGOs that work with agriculture, water, environment especially in the Arid and Semi-Arid Lands (ASAL).

HENNET's Secretariat and County Chapters' institutional capacity will be strengthened so that they can optimize the resources of their partners and expand CSO involvement in immunization at the national and county level. HENNET will play the major role in advocacy, social accountability, outreach activities, community mobilization and demand creation. A community of practice will be established and a system will be developed to feed data collected by the CSOs into the National Health Information System (HIS). This will support in enhancing data quality right from the grass root levels.

HENNET will be conduct annual joint review forums with MOH, CSOs, Secretariat, and community leaders on separate occasions in respect to objectives to be attained.

***Pooled fund** applicants are required to summarise the role of CSOs in the implementation of the sector wide programme.*

21. Risks and mitigation measures *(Maximum 2 pages)*

If available, provide Attachment #35: Health Sector Risk Assessment. If such an assessment is not available, provide an analysis of the risks of not achieving the objectives in this application.

Complete the table below for each of the proposed objectives outlined in Question 12. If the risk is categorised as 'high', please provide an explanation as to why it is 'high'.

Description of risk	***PROBABILITY*** ***(high, medium, low)***	***IMPACT*** ***(high, medium, low)***	***Mitigation Measures***
Objective 1			
Institutional Risks: - County autonomy resulting to non-uniform county governance structures for the health sector - National government organisational change resulting to staff movements with risk of loss of institutional memory	*Low* *Low*	*Low* *Medium*	*- County specific approaches* *- Organisational adjustment and adaptation through systematic handing over, orientation and induction packages*
Fiduciary Risks: - Audit issues may not be adequately addressed in time - Alignment of GAVI calendar to GoK financial calendar. Funds may not be captured in 2016-2017 budget - Risk of mis-application of HSS grant disbursed to	*Medium* *High* *Medium*	*Medium* *Low* *Medium*	*- Funds may be channelled through in-country Gavi alliance partners e.g. UNICEF/WHO* *- Funds may be channelled through in-country Gavi alliance partners e.g. UNICEF/WHO*

the counties as counties have some autonomy			*- As these are donor funds disbursed by the National government, the utilization of the funds will follow agreed work plans. Financial and programmatic reports of implementation will determine disbursements. The dedicated accounts for the funds will also be subject to financial management act including regular audits by Auditor general*
Operational Risks: -Procurement processes may delay starting time	*Medium*	*Low*	*-Early pre-qualification*
Programmatic and Performance Risks: Staff turnover at both county and national levels	*Low*	*Medium*	*- On-job orientation*
Other Risks:			
Overall Risk Rating for Objective 1	*Medium*	*Medium*	
Objective 2			
Institutional Risks: -County autonomy resulting to possible lack of sustainability of Gavi HSS supported activities -Low commitment of immunisation staff due to challenges linked to transition to devolved governance -Strikes by health workers	*Medium* *Medium* *Medium*	*Medium* *Medium* *Medium*	*-Advocate with county government for budgetary allocations for immunization services* *-Advocate for county to put in place recognition and staff retentions system for good performance* *-training of critical mass of vaccinators and supervisors*
Fiduciary Risks: -Fraud	*Low*	*Medium*	*-Strict adherence to procurement and financial procedures*

			instituted by Government and improved oversight
Operational Risks: -Reduction in numbers of key human resource at county level due to uncertainties of devolution of services to counties. -Competing priorities in case of disease outbreaks and other emergencies; -Inadequate numbers of trained health promotion officers delaying implementation	*Medium* *Medium* *Low*	*Medium* *Medium* *Low*	*-Advocate with county government to put in place Recognition and staff retentions system for good performance;* *-Strengthening surveillance systems for early detection and response to outbreaks and public health events.* *- use of public health officers*
Programmatic and Performance Risks: -Low capacity of new county managers in program management; weak stakeholders' coordination at county level	*Low*	*Medium*	*-Enhancing capacity of sub county managers in planning, performance monitoring and mentorship by national level*
Other Risks:			
Overall Risk Rating for Objective 2	*Low*	*Medium*	
Objective 3			
Institutional Risks: - Lack of commitment of maintenance by staff leading to delays in repair of broken down equipment. - Inadequate numbers of Cold Chain maintenance staff	*Low* *Medium*	*Medium* *Medium*	*-By facilitating the transport and toolkits for the Cold Chain maintenance staff will reduce equipment downtime and sensitize HW on importance of early reporting* *-Increase the number of Cold chain maintenance staff through mentorship*

Fiduciary Risks: -External: 1) Theft of Equipment	*Low*	High	*-Improving CCE inventory and stock management*
Operational Risks: -External: Lack of adequate commitment by Division of health information system may delay establishing monitoring system for cold chain; commitment by healthcare provides to collect quality data -Internal: Availability of adequate technical staff to maintain new information system	*Medium* *Medium*	*Low* *Low*	*-Joint planning with key stakeholders; establishment of program team at EPI program for HSS grant;* *-Training of adequate numbers on maintenance of the new information system*
Programmatic and Performance Risks: -Poor monitoring and evaluation framework leads to lack of intuitive response and accountability -Standards and norms not being adhered to by health workers. HWs knowledge and practices not up to date with current EPI guidelines	*Medium* *Medium*	*High* *High*	*-Strengthen and implement the monitoring and evaluation framework for decision making* *-By availing orientation packages to new Health workers on EPI guidelines and providing consistent support supervision*
Other Risks:			
Overall Risk Rating for Objective 3	*Medium*	*Medium*	
Objective 4			
Institutional Risks: -Staff movement leading to loss of trained staff -Inadequate skills among county and sub-county staff for M&E	*Medium* *Medium*	*Medium* *Medium*	*-Advocacy with County Government to put in place staff retention mechanisms* *-Continuous training in basic and advanced M&E for all program staff and supervisors; regular*

			review meetings and feedback
Fiduciary Risks: -Data Fraud (low data quality)	*Low*	*Medium*	*-Regular Data Quality Self Assessments and data quality audits* *-Use of electronic systems for data management and archiving*
Operational Risks: -Delayed reporting of coverage data and inadequate infrastructure to capture other important programmatic data	*Medium*	*Low*	*-Review of EPI program M&E system and develop plans to improve linkage to other information systems like Stock Management Tools and to improve reporting of Cold chain and other program data*
Programmatic and Performance Risks: -Competing tasks at the health facilities hence which affect perceptions on importance of data -Loss of data	*Medium* *Medium*	*Medium* *Medium*	*-Regular supportive supervision and DQSA to emphasize role of data in programme management* *-Use of electronic systems for data management and archiving*
Other Risks:			
Overall Risk Rating for Objective 4	*Medium*	*Medium*	
(Add more rows for additional objectives as required)			
Pooled fund *applicants are required to provide any risk mitigation plan under the sector wide/ pooled funding mechanism.*			

22. Financial management and procurement arrangements

Describe the proposed budgetary and financial management mechanisms for the grant

The grant financial and budgetary procedures will be based on the Public Financial Management Act 2012. This act mandates the Principal Secretary of the Ministry of Health to be the accounting officer responsible for all public funds both from GOK and development partners. The accounting officer must authorize and approve all public expenditures and the overall financial management process. Both budgetary and financial processes will be executed and co-ordinated by the Project Management Unit (PMU)

The equipping and running of the PMU office shall be facilitated by the HSS grant. The role of PMU is to link with different implementing agencies in ensuring that project implementation is on course and in compliance with the approved work plan. It provides an oversight role to all implementing agencies. The PMU is responsible for ensuring that all expenditure including personal allowances relating to the project are in compliance with existing government guidelines and circulars as also provided by PFM Act 2012

Procurement of cold chain equipment will be done through UNICEF.

The following are the main constraints in the health sector's budgetary and financial management system:

- Long and cumbersome public procurement procedures
- Inadequate budgetary allocation by the National Government to the Health Sector
- Non-harmonized financial management system between donor reporting and GOK reporting
- Non-alignment of the Donor and GOK financial reporting periods for example, GOK financial year commences in July while for most donors, the calendar year is used.
- Delays in appraising audit-related issues

*Complete the **Budgetary and Financial Management Arrangements Data Sheet** (below) for each organisation that will directly receive HSS grant finance from Gavi.*

*Provide **Mandatory Attachment #7**: Detailed two-year Procurement Plan*

***Pooled fund** applicants are required to provide relevant documents for financial management and procurement under the pooled funding arrangement*

Budgetary and Financial Management Arrangements Data Sheet	
Any recipient organisation/country proposed to receive direct funding from Gavi must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).	
1. Name and contact information of Focal Point at the Finance Department of the recipient organisation.	Mr. Benn Khadiagala Senior Chief Finance Officer Ministry of Health,

	P.O. BOX 30016-00100 Nairobi
2. Does the recipient organisation have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	YES
3. If YES: • Please state the name of the grant, years and grant amount. • For completed or closed Grants of Gavi and other Development Partners: Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. For on-going Grants of Gavi and other Development Partners: Please provide a brief description of any financial management and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	GAVI HSS Grant 2007/2008 Financial Year-ongoing though dormant since 2012. Financial, management and procurement implementation issues related to the above grant: • Overdue/delayed audit reports • Qualified audit reports for the GAVI HSS • Delayed procurements due to lengthy procedures as per the Public Procurement and Disposal Act 2012
Oversight, Planning and Budgeting	
4. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	Child Health Interagency Coordinating Committee (ICC) Ministry of Health, Development Partners for Health in Kenya, In-country partners, CSO Meetings are held quarterly. Decision making is by consensus or by vote.
5. Who will be responsible for the annual planning and budgeting in relation to Gavi HSS?	Project Management Unit will be responsible for the overall planning and budgeting for the GAVI HSS project
6. What is the planning & budgeting process and who has the responsibility to approve Gavi HSS annual work plan and budget?	The planning process is initiated by National level and cascaded downwards to all levels up to the community level. The role of the national level is to provide guidelines and build capacity. The Child Health ICC has the role of reviewing and approving GAVI HSS annual work plans.
7. Will the Gavi HSS programme be reflected in the budget of the Ministry of Health submitted every year to the Parliament for approval?	YES
Budget Execution (incl. treasury management and funds flow)	

8.	What is the suggested banking arrangement? (i.e. account currency, funds flow to programme) Please list the titles of authorised signatories for payment release and funds replenishment request.	HSS funds from GAVI will be deposited in the GAVI-HSS US Dollar account at Central Bank of Kenya (CBK). Funds will be transferred (see attachment 45- Financial management oversight) to MOH GAVI Project account in Kenya Shilling. The signatories will be Head Account Unit, Head Department of Promotive and Preventive Health Services, and Senior Chief Finance Officer
9.	Will Gavi HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	Ministry of Health GAVI account at CBK
10.	Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- "pooled account")?	YES, only GAVI funds
11.	Within the HSS programme, are funds planned to be transferred from national to sub-national levels (provinces, districts etc.)? If YES, please describe how fund transfers will be executed and controlled, including stating what time of year (month/ quarter) funding must be received at the national level in order to disburse to sub-national levels in a timely manner.	YES, the GAVI HSS funds will be received by National Treasury and then transferred to the MOH GAVI Project Account at CBK. Funds relating to counties will be disbursed in form of Authority to Incur Expenditure in the same form as the World Bank supported Health Sector Services Fund (HSSF). The funds will be disbursed to the counties on quarterly basis to enhance proper monitoring and reporting of expenditure.
Procurement		
12.	What procurement system will be used for the Gavi HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)	For GAVI funds transferred to MOH (GOK), the method of procurement will be provided for by the Public Procurement and Disposal Act 2012. For CSOs GAVI HSS funds, the method of procurement will be as per the development partner's procurement procedures. For funds transferred to lead UN agencies like UNICEF/WHO, procurement will be in line with UN procurement procedures.
13.	Are all or certain items planned to be procured through the systems of Gavi's in-country partners (UNICEF, WHO)?	Specialized cold chain equipment will be procured through UNICEF
14.	What is the staffing arrangement of the organisation in procurement?	

15. Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES
16. Is there a functioning complaint mechanism? Please provide a brief description.	YES The PPD Act 2012 has provided for mechanisms where a merchant with complaints arising from procurement may be addressed. There are two bodies provided by the Act to address complaints and resolve disputes. These are Public Procurement Oversight Authority (PPOA) and the Public Procurement Tribunal
17. Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES There are two bodies provided by the PPD Act to address complaints and resolve disputes. These are Public Procurement Oversight Authority (PPOA) and the Public Procurement Tribunal
Accounting and financial reporting (incl. fixed asset management)	
18. What is the staffing arrangement of the organisation in accounting, and reporting?	The Account Unit in the Ministry of Health is headed by the Senior Assistant Accountant General. The unit is responsible for the overall accounting of all public funds including donor funds. It is based at the Ministry of Health Headquarters with 82 personnel. The Division of Family Health where the GAVI HSS project is based has an accounts section headed by a Senior Accountant with 4 personnel. The section reports to the Head of the Account Unit in the Ministry of Health.
19. What accounting system is used or will be used for the Gavi HSS Programme? (I.e. is it a specific accounting software or a manual accounting system?)	The Government of Kenya through National Treasury uses the Integrated Financial Management Information System (IFMIS) in processing

	all financial transactions for both GOK-funded and donor-funded budgetary allocations.
20. How often does the implementing entity produce interim financial reports and to whom are those submitted?	The IFMIS is a real time system capable of producing financial reports on need basis. However for planning and monitoring purposes, these reports will be produced on quarterly basis.
Internal control and internal audit	
21. Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	YES The Public Financial Management Act and its relevant financial regulations provide the framework of financial reporting and control. Similarly, the Chart of Accounts provides for the accounting procedures
22. Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will be involved in relation to Gavi HSS.	YES The PFM Act 2012 provides for the office of Internal Auditor in each institution including all public bodies. This is an independent office that reports to the accounting officer and the audit committee. From time to time, the office reviews all operational and financial transactions to ensure value for money. GAVI HSS funds will be subjected to internal audit reviews. All commitments and encumbrances have to be authorised by an internal audit office before processing for both GOK and Donor funds.
23. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	YES The PFM Act 2012 further provides the establishment of an Audit Committee in each

	Ministry, Department and Agencies (MDA). The role of the Audit Committee is to review recommendations for both internal and external auditors and guide in the implementation. The Ministry of Health has a functional Audit Committee.
External audit	
24. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[7]	YES All MDAs are required by law to prepare financial statements at the end of each financial year and submit them to the Office of Auditor General by 30th September every year for audit. However, there is provision for a donor to engage a private auditor to complement the Office of Auditor General. This provisional law applies for both GOK and donor-funded budgetary allocations.
25. Who is responsible for the implementation of audit recommendations?	Implemented. This responsibility is delegated to Project Management Unit.

Budgetary and Financial Management Arrangements Data Sheet (CSO)	
Any recipient organisation/country proposed to receive direct funding from Gavi must complete this Data Sheet (for example, MOH and/or CSO receiving direct funding).	
26. Name and contact information of Focal Point at the Finance Department of the recipient organisation.	Johnpaul Omollo National Coordinator

[7] If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget.

	Health NGOs Network (HENNET), P.O. BOX 30125-00100 Nairobi
27. Does the recipient organisation have experience with Gavi, World Bank, WHO, UNICEF, GFATM or other Development Partners (e.g. receipt of previous grants)?	YES
28. If YES: • Please state the name of the grant, years and grant amount. • For completed or closed Grants of Gavi and other Development Partners: Please provide a brief description of the main conclusions with regard to use of funds in terms of financial management performance. For on-going Grants of Gavi and other Development Partners: Please provide a brief description of any financial management and procurement implementation issues (e.g. ineligible expenditures, mis-procurement, misuses of funds, overdue / delayed audit reports, and qualified audit opinion).	GAVI CSOs strengthening project. The grant was received over the period 2010-2012, 2013-2015, 2016-2017 (on going) Financial, management and procurement implementation issues related to the above grant: • Audit reports done in time • Unqualified audit report • Sub grant renewed Integrated MCH project funded by European Union 2013-2015 • Audit reports done in time • Unqualified audit report • Successful closure of the project
Oversight, Planning and Budgeting	
29. Which body will be responsible for the in-country oversight of the programme? Please briefly describe membership, meeting frequency as well as decision making process.	Child Health Interagency Coordinating Committee (ICC) Ministry of Health, Development Partners for Health in Kenya, In-country partners, Meetings are held quarterly. Decision making is by consensus or by vote.
30. Who will be responsible for the annual planning and budgeting in relation to Gavi HSS?	The HENNET Secretariat and Board will be responsible for the overall planning and budgeting for the GAVI HSS project. The plans and budgets will be approved by the ministry of health Kenya.
31. What is the planning & budgeting process and who has the responsibility to approve Gavi HSS annual work plan and budget?	The plans and the budgets will be developed by the HENNET secretariat in conjunction with the implementing CSOs. The plans will be presented to the HENNET board and further to the Ministry of health for approval. Once the three =bodies have approved, the Child Health ICC has the overall role of reviewing and approving GAVI HSS annual work plans.
32. Will the Gavi HSS programme be reflected in the budget of the Ministry of Health	YES

	submitted every year to the Parliament for approval?	
Budget Execution (incl. treasury management and funds flow)		
33.	What is the suggested banking arrangement? (i.e. account currency, funds flow to programme).Please list the titles of authorised signatories for payment release and funds replenishment request.	HSS funds from GAVI will be deposited in the GAVI-HSS US Dollar account at NIC Bank. Funds will be transferred to HENNET GAVI Project account in Kenya Shilling. The signatories will be the Board Chairperson, The Boards secretary and the board Treasurer.
34.	Will Gavi HSS funds be transferred to a bank account opened at the Central Bank or at a commercial bank in the name of the Ministry of Health or the Implementing Entity?	The GAVI funds will be transferred to the HENNET GAVI account at NIC bank
35.	Would this bank account hold only Gavi funds or also funds from other sources (government and/or donors- "pooled account")?	YES, only GAVI funds
36.	Within the HSS programme, are funds planned to be transferred from national to sub-national levels (provinces, districts etc.)? If YES, please describe how fund transfers will be executed and controlled, including stating what time of year (month/ quarter) funding must be received at the national level in order to disburse to sub-national levels in a timely manner.	YES, the GAVI HSS funds will be received by the National HENNET secretariat once every year at the beginning of the year. The funds shall be disbursed to implementing CSOs on quarterly basis through electronic funds transfer. The disbursement slips shall be presented to the MoH as evidence of funds disbursed.
Procurement		
37.	What procurement system will be used for the Gavi HSS Programme? (e.g. National Procurement Code/Act or WB/UNICEF/WHO and other Development Partners' procurement procedures)	HENNET will not be purchasing any capital assets
38.	Are all or certain items planned to be procured through the systems of Gavi's in-country partners (UNICEF, WHO)?	N/A
39.	What is the staffing arrangement of the organisation in procurement?	HENNET has a team composed of Board members and the management team that often takes care of any purchase of capital assets
40.	Are there procedures in place for physical inspection and quality control of goods, works, or services delivered?	YES
41.	Is there a functioning complaint mechanism? Please provide a brief description.	N/A
42.	Are efficient contractual dispute resolution procedures in place? Please provide a brief description.	YES There are two bodies provided by the PPD Act to address

	complaints and resolve disputes. These are Public Procurement Oversight Authority (PPOA) and the Public Procurement Tribunal
Accounting and financial reporting (incl. fixed asset management)	
43. What is the staffing arrangement of the organisation in accounting, and reporting?	HENNET has an accountant who is in charge of all financial obligations. Approvals are done by the national coordinator. All the payments and cheques are approved for payments by the HENNET chairperson, Secretary and treasurer.
44. What accounting system is used or will be used for the Gavi HSS Programme? (I.e. is it a specific accounting software or a manual accounting system?)	HENNET uses quick books for accounting. The accounting software is digital and well integrated within the reporting systems in HENNET
45. How often does the implementing entity produce interim financial reports and to whom are those submitted?	HENNET often does monthly report to various donors including GAVI CSOs. HENNET shall produce and submit quarterly finance reports.
Internal control and internal audit	
46. Does the recipient organisation have a Financial Management or Operating Manual that describes the internal control system and Financial Management operational procedures?	YES HENNET has a functional finance and procurement manual that spell out the internal controls.
47. Does an internal audit department exist within recipient organisation? If yes, please describe how the internal audit will be involved in relation to Gavi HSS.	An internal audit department does not exist. However, as spelt out in the finance manual section 15.4, a Special Audits may be conducted by such authority, for such purposes and within such period as shall be approved by the Board. The management will ensure that outside the day-to-day routine

	of the system, they include the overall supervisory controls, the review of management accounts and comparison thereof with budgets, the internal audit function and any other special review procedures.
48. Is there a functioning Audit Committee to follow up on the implementation of internal audit recommendations?	YES The finance committee within the Board of directors is mandated to ensure all issues of finance including internal and external audit reports are duly addressed.
External audit	
49. Are the annual financial statements planned to be audited by a private external audit firm or a Government audit institution (e.g. Auditor General)?[8]	YES HENNET conducts annual audits starting October of every year. The reports are supposed to be presented to the Board and further to the Annual General Meeting for perusal and criticism. The AGM approves the audit reports. However, there is provision for a donor to engage a private auditor to complement the work done by the private auditors engaged by the platform.
50. Who is responsible for the implementation of audit recommendations?	The HENNET Board of directors (finance committee) is responsible for the implementation of the audit recommendations.

[8] If the annual external audit is planned to be performed by a private external auditor, please include an appropriate audit fee within the detailed budget.