

Joint appraisal report

When submitting this report, the country confirms that the grant performance framework has been reviewed as part of this joint appraisal. Performance against agreed metrics has been analyzed, and explained where relevant.

Country	KENYA
Reporting period	JULY 2015- JUNE 2015
Fiscal period	JULY 2015- JUNE 2016
If the country reporting period deviates from the fiscal period, please provide a short explanation	
Comprehensive Multi Year Plan (cMYP) duration	JULY 2015- JUNE 2019
National Health Strategic Plan (NHSP) duration	JULY 2014- JUNE 2018

1. SUMMARY OF RENEWAL REQUESTS

[These tables will be pre-populated by the Gavi Secretariat. If there are any changes to be made, this should be discussed as a group during the joint appraisal and flagged in the report – see the guidance document for more details]

Programme	Recommendation	Period	Target	Indicative amount paid by Country	Indicative amount paid by Gavi
DTP-HepB-Hib, 10dose/vial, Liquid	<i>Renewal</i>	2017	1,495,936	US\$ 805,000	US\$ 7,664,500
PCV10, 2dose/vial, Liquid	<i>Renewal</i>	2017	1,495,936	US\$ 1,343,500	US\$ 15,269,500
Rotavirus, 2-dose schedule	<i>Renewal</i>	2017	1,495,936	US\$ 666,500	US\$ 6,153,500
IPV, 10dose/vial, Liquid	<i>Renewal</i>	2017	1,219,047	US\$ 0	US\$ 1,446,000
Yellow fever, 10dose/vial, Lyophilized	<i>Renewal</i>	2017	42,516*	US\$ 7,500	US\$ 71,000

*90% of the estimated total surviving infants in Baringo and Elgeyo Marakwet, 2017

Indicate interest to introduce new vaccines or HSS with Gavi support*	Programme	Expected application year	Expected introduction year
	<i>HPV, Single dose vial, Liquid</i>	2017	2018
	<i>CCEOP Support</i>	2016	2017

*Not applicable for countries in final year of Gavi support

2. COUNTRY CONTEXT (maximum 1 page)



This section does not need to be completed for joint appraisal update in interim years

[If relevant, comment only on any changes since the previous joint appraisal to key contextual factors that directly affect the performance of Gavi grants – see guidance document for more details]

OVERALL HEALTH SYSTEM**Devolution of health services**

Kenya enacted a new constitution in 2010 that recognizes social and economic rights such as health, education, water, food, social security, among others. It also places great emphasis on the marginalized and disadvantaged groups such as women, youth, children and the disabled. The constitution also devolved political power and governance to two levels of government, National and 47 semi-independent counties which have clearly defined functions. The 47 county governments are led by elected Governors and 1,450 ward representatives. County assemblies provide oversight over county executives led by an elected Governor and County Executive Committee Members appointed by the governor and approved by members of County Assembly. The counties receive budgetary allocation from national treasury through a clearly defined revenue allocation criteria, to implement county specific integrated plans after approval by the county assembly. The national government has no direct control on how much is allocated to any of the devolved sectors, including health sector, at county level but can influence the planning and budgetary making process through advocacy and enhancing the capacity of counties in evidence based planning.

Following the 2013 national elections and as part of the process of implementing the new constitution, the newly elected government rapidly devolved health services including Human Resources Management to the 47 counties. The constitution clearly defines the functions of the two levels of government. The national government is responsible for service delivery at 4 tier-six hospitals (national referral and teaching hospitals); procurement of vaccines including Gavi supported vaccines, distribution of vaccines to the 9 regional vaccine stores; procurement of cold chain equipment through the CCEOP; policy development; research; advocacy; resource mobilization; capacity building of County staff; oversight on quality and standards and management of the health information system. Immunization service provision is guided by national vaccination policy.

The County governments are responsible for oversight of all the 6169 health facilities nationwide (public, Faith Based and private) providing immunization services, delivery of vaccines from the Regional depots to the sub-county stores and health facilities; procurement and distribution of cold chain equipment, injection and injection safety devices to health facilities; printing of data collection and reporting tools; communication and social mobilization; resource mobilization; support supervision and reporting of data at the county level. The level of support provided to the health sector including immunization services varies across counties with performance largely dependent on the extent to which the county political leadership supports the technical arm to provide oversight to frontline health workers.

Following devolution of health services, the National government has engaged with counties to advocate for increased financing for the health sector and supported the development of County integrated plans. The National EPI program has held several stakeholder meetings with county executives and technical staff and parliamentarians as part of advocacy for immunization. Clarity on the roles and responsibilities across the two levels of government is improving following several advocacy engagements between the two levels of government. Following these interventions, there is notable increased investment in expanding access to health services across all counties while procurement of vaccines has now reverted to the National government compared to the situation in 2013/14. County governments are employing additional technical staff, building and equipping new health facilities and procuring cold chain equipment. Communities are increasingly participating in planning, budget allocation and demanding accountability as defined in the constitution while immunization services have better visibility. These positive developments are expected to contribute towards improved health outcomes in the coming years.

While the above positive changes have been noted following devolution, there is need to continue addressing challenges linked to management of human resources at county level, weak linkages across counties and with national government, coordination of stakeholders at county and national level and timely and adequate financing for health commodities especially injection and safety devices, lack of technical support supervision and performance review meetings across many counties. While the NVIP is mandated to enhance the capacity of counties to deliver quality immunization services, the program is constrained financially to effectively undertake its functions.

Of crucial concern to the immunization program is the inadequate and delays in financing for

procurement of injection devices for BCG and Measles by counties. This has negatively affected bundling of vaccines and injection devices and has contributed to missed opportunities for vaccination and declined performance for other antigens. Addressing sustainable financing for injection devices and operational costs, hastening the establishment of sector coordination mechanisms (HSCC) in line with devolution and budget expenditure tracking at county and national level are crucial areas of intervention.

Management and Governance of the Immunization services

At national level, health is headed by a cabinet secretary while the accounting officer is the principal secretary both not being elected officials. At the county level, their equivalents are the County Executive Committee Member (CEC) and Chief Officer respectively. County level structures are determined by each county based on their peculiarity. An Intergovernmental forum, established as a coordinating mechanism between the two levels of government. This forum is coordinated by the department of intergovernmental relations within the ministry of health.

The National Immunization services in Kenya are managed by the Ministry of Health through the National Vaccines and Immunization Program (NVIP) and the Disease Surveillance and Response Unit (DSRU). NVIP provides policy direction, oversight and technical support to implementation for the routine immunization while DSRU manages vaccine preventable diseases surveillance and outbreak response. The two programs are classified as strategic national programs and report through their respective divisional heads to the Director of Medical services.

Immunization services in Kenya are currently coordinated at 3 levels: The Health Sector Coordinating Committee, The Child Health ICC (CH-ICC) and Technical working group. The HSCC is the top policy decision making organ that provides the oversight to the health sector and is chaired by the Principal Secretary for Health (PS) with membership from heads of UN agencies, Development Partners for Health (DPHK) and CSO representatives through the secretariat (HENNET). The Child Health-ICC (CH-ICC) reports to the HSCCC and provides a forum for coordination of investments in child and adolescent health, supports management of key action points and oversees the work of appointed technical working groups and taskforces. Membership to the CH-ICC comprises of MoH, development partners, Health NGOs Network (HENNET) and Faith Based Organizations. It is chaired by the DMS and is required to meet quarterly with provision for special meetings if necessary. The ICC is a platform for interagency coordination, resource mobilization, and policy guidance. The CH-ICC also receives technical inputs from technical working groups that are set up with authority and approval by the ICC for particular topics and areas such as new vaccine introductions, proposals and applications, and campaigns. The National Immunization technical working group is led by the EPI manager and is accountable to the CH-ICC. Membership to the TWG consists of program leads from the partner organizations and CSO supporting immunization program.

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

Kenya National Immunization Technical Advisory Group (KENITAG) established to provide independent technical guidance on immunization to the Ministry of Health. There is advanced planning to establish AEFI Technical Advisory Committee to support decision making in effectively addressing AEFIs.

The established coordination mechanisms for the health sector are currently weak with the HSCC and CH-ICC not meeting regularly. The HSCC is currently being reconstituted. To address this challenge, the Ministry of health is currently finalizing a Partnership Framework that will define how the sector is coordinated under a devolved system. Meanwhile the above coordination arrangements are in place. The KENITAG secretariat is currently underfunded thereby negatively affecting its functionality while AEFI advisory committee is yet to be established. There is need for continued technical and financial support to the KENITAG and AEFI Advisory Committee to ensure functionality of these crucial decision making bodies.

Human resources capacity

As provided by the 2010 Kenya constitution, health services were devolved in 2013 and hence management of the health workforce became one of the functions of the County government. New managers and health care providers were appointed/deployed/recruited to provide health services. Some of the newly deployed county EPI focal persons have limited capacity as they have not undergone training in Mid-Level Management on EPI. After devolution, there has been a high staff turnover with new staff being deployed to the immunization station. Most of the staff have not undergone operational level training

The national government with support from partners has strengthened competence and skills of tutors in medical training institutions to improve the competencies of pre-service medical and nursing students. Financial constraint has however limited operational level training of in-service healthcare providers. Currently less than 1% of frontline health workers receive EPI updates in any given year. The EPI program has posted the following on web site to improve availability of current information on EPI: Vaccination policy and EPI health worker and physician manuals.

Devolution of health services also places additional management responsibilities to health managers at County and sub-county levels especially in program management, advocacy, resources mobilization and leadership. In 2015, 43 managers have been trained in MLM while 47 county Medical Engineering Technologists have been trained in cold chain repairs and maintenance.

Continued delays in payment of salaries by some counties and the lack of clear system for staff promotions and motivation has resulted to low staff morale with resultant resignation of staff and frequent strikes of health workers that negatively affects service delivery. There is therefore need to address financial constraints facing the NVIP in enhancing the capacity of County EPI teams to be able to have these core competencies. While there are currently 35,000 community health volunteers in the country who are involved in immunization related activities such as defaulter tracing and social mobilization, there is a need for building their capacity on EPI specific areas, including provision of job aids.

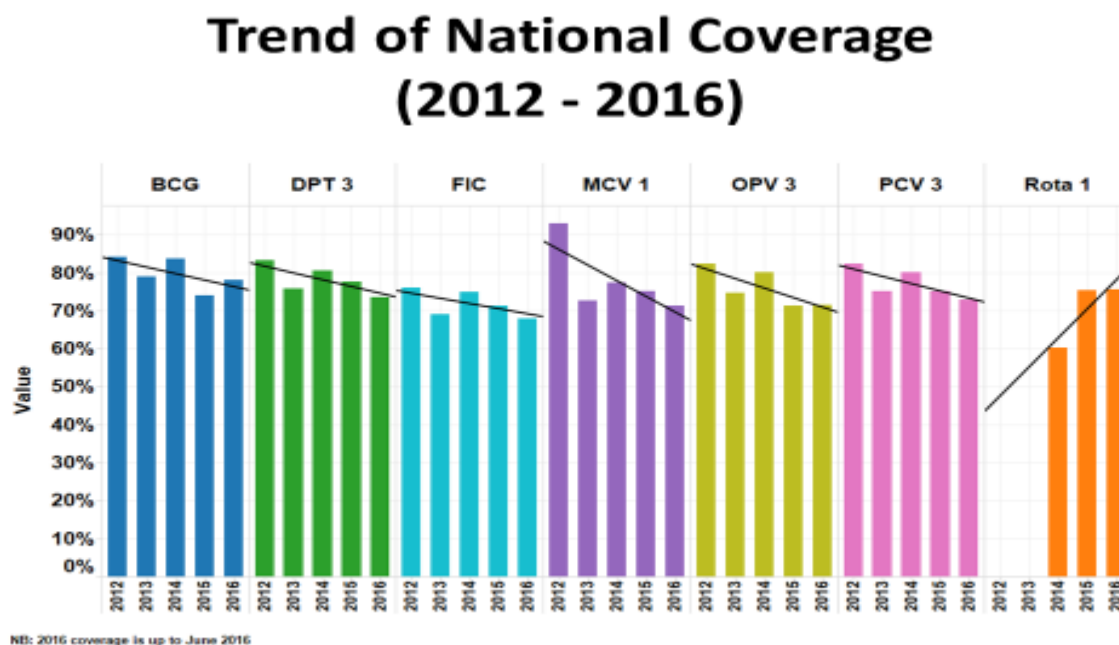
Coverage

Kenya provides seven vaccine formulations through the national routine immunization programme. This includes IPV that was introduced in 2015 with support from Gavi. In 2015, an estimated 1,727,698 children were born of whom 1,549,625 survived. Of the surviving infants, 75% received three doses of Penta vaccine, 75% PCV10, 75% Rota 1 and 20% YF (draft JRF 2015). This performance indicates general decline in immunization coverage in 2015 compared to 2014. A two-year HPV vaccine demonstration project conducted in one county between 2013 and early 2015 achieved coverage of 96 and 86 percent in the first and second year respectively.

Data quality handling at service delivery has also contributed to declining administrative immunization coverage as indicated by the recent data quality assessment conducted in 4 counties. There is inadequacy in data management as indicated in the already shared report on Kenya data improvement plan.

The dropout rate between Penta 1 and Penta 3 is good indicator of program continuity and follow-up of children in EPI. In 2015 the national Penta 1 – Penta 3 dropout rate was 7.2%, which is less than the target of point of 10% and a sign of good utilization. Only eight Counties had dropout rate of above 10%. The routine administrative coverage of Measles second dose remains very low with only 28% of the eligible children receiving the vaccine. However, from the recent measles coverage survey preliminary results measles second dose stands at 55% of the eligible children aged between 12 months to 23 months.

Figure 1 Trend of National coverage (2012-2016)



Kenya conducted Nationwide MR campaign in May 2016 to address the high population immunity gap against Measles and rubella and as initial step towards introduction of MR vaccine. During the vaccination campaign, an estimated 19.2 million children aged between 9 months and 14 years were vaccinated.

Preliminary coverage survey results indicate that the majority of counties (45) performed = or > 95% while only 2 counties (Turkana and Mandera) achieved coverage of <95 % this performance is related to insecurity issues.

While coverage for most vaccines has declined due to the challenges attributed to instability caused by sudden changes in governance, the immunization program has shown resilience. However, key components of immunization require strengthening. The decline in coverage is attributed to a weak vaccine stock management resulting in stock outs at health facilities, stock out of injection devices, lack of consistent financing for outreaches and mobiles amongst disadvantaged populations, weak data review and quality assurance mechanisms at county level, vaccine hesitancy and low data quality including lack of performance review mechanism that is crucial to identifying areas of weakness and developing corrective actions.

Equity

Between 2014 and 2015, the number of reporting sub-counties (districts) has increased from 285 to 300 with the number of Health Facilities increasing from 5800 to 6190 during the same period. An estimated 400,000 children are under-vaccinated (DPT3) in 2015 in Kenya half of them in 67 sub-counties. The number of under vaccinated children has increased by 33,000 between 2014 and 2015. Variations in vaccination coverage across and within counties persist. Access to immunization services, as measured by Penta 1 coverage, is 81% compared to 86% in 2014 with half of sub-counties reporting less than 80% Penta 1 coverage in 2015. Of the 299 Sub-Counties reporting in 2015 only 35.1% (105) reported pentavalent 3 coverage of 80% and above. Only 35.8% of the Sub-Counties had good utilization and access, a decline of 4.2 percentage point from 2014. Nairobi, the county with highest number of urban population, contributed 10% of under vaccinated (Penta 3) children of the total

number of under-vaccinated children in the country. Low coverage (35%) have also been reported in Mandera county, which has suffered several years of insecurity.

Analysis of January to June 2016 data shows that dropout rates between Pentavalent 1 and Pentavalent 3 range between a low of 0.88% in Makueni County and 26.09% in Tana River County. There are a total of sixteen (16) counties with dropout rates greater than 10%. These are: Baringo, Garissa, Isiolo, Kilifi, Kwale, Mandera, Marsabit, Mombasa, Nandi, Narok, Samburu, Tana-River, Trans-Nzoia, Turkana, Wajir and West-Pokot. In addition, the counties with the highest number of sub-counties with dropout rates greater than 10% are in Mandera and Nandi County.

The number of unimmunized children continues to vary across counties. The three (3) counties with the highest number of unimmunized children for Pentavalent 3 are Mandera, Nairobi and Bungoma County with a total of 18,282 and 16,266 and 10,205 children respectively. Nairobi is the largest city in Kenya with a high population living in informal settlements. Majority of the underserved population are in informal settlement. Following SARAM (2013), only 34% of primary health facilities in Nairobi provide in immunization services. Activities for urban programming in Nairobi have been included in the HSS. In contrast, Kiambu County records no unimmunized children for Pentavalent 3.

The majority of these counties are targeted through the Gavi HSS grant. The remaining counties are targeted through the Technical Country Assistance and other local partnerships.

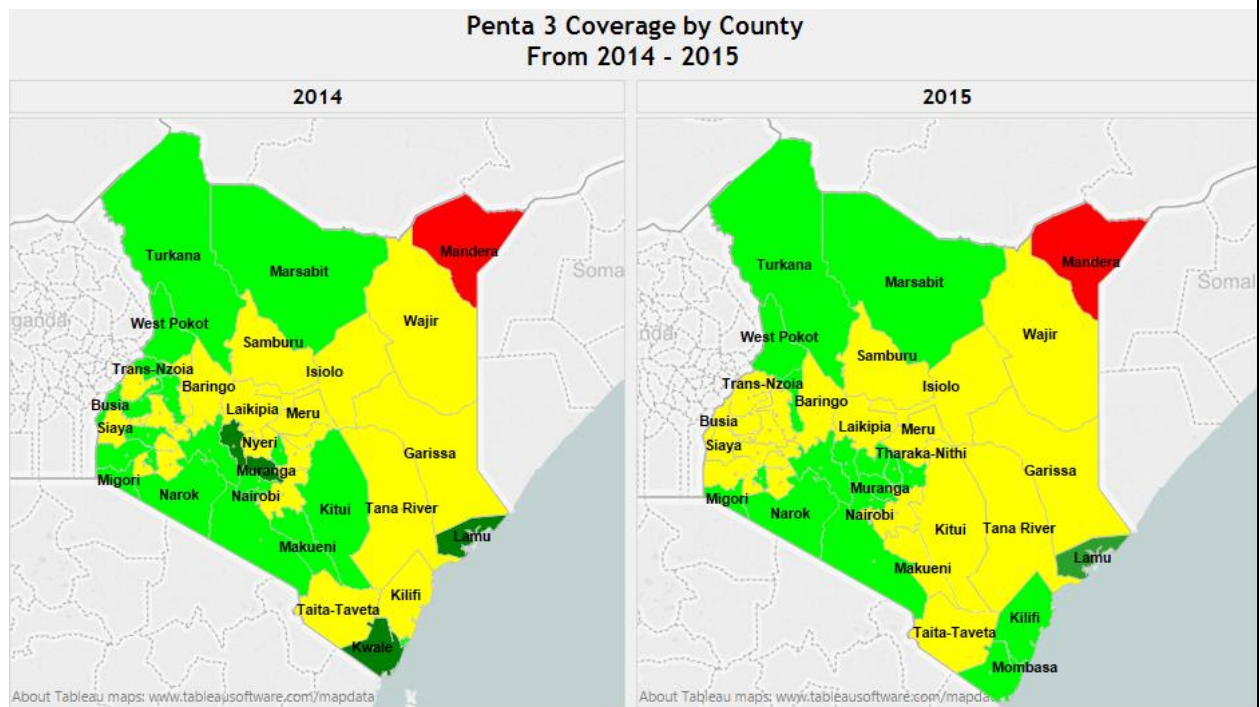
Analysis of health DHS 2014 reports lowest vaccination coverage amongst households in the lowest wealth quintile, with no education and in rural areas. At the national level, there is no difference in immunization coverage based on sex. The picture at sub national level may however be different and there is need to validate these assumptions with surveys such as the DHS 2014. Trend analysis from 1989 to 2014 confirms that access to education and wealth are the two major determinants for full immunization. The 2014 data shows that the declining gaps in coverage between rich-poor and Educated-less Educated household reported prior to 2014 DHS is reversing.

Increasing inequities may be attributed to decline in implementation of outreaches and mobile strategies that are designed to reach the hard to reach populations and sporadic and ad hoc industrial action by health workers. Services to Northern Counties like Mandera has been adversely affected by insecurity while Nairobi has suffered poor timing of services that has adversely affected communities living in informal settlements.

The government of Kenya is currently implementing an initiative to avail services to informal settlements in major cities through "Container clinic initiative". Security challenges in Mandera are being addressed while the National government continues to engage with the Counties and other stakeholders to increase operational level support for immunization program. There is however need to undertake an in depth analysis of county performance to better understand where the most excluded children are. A comprehensive review of the immunization program is also urgent to help identify and quantify the major bottlenecks and additional strategies that can be deployed to address them.

The figures below present National and county performance.

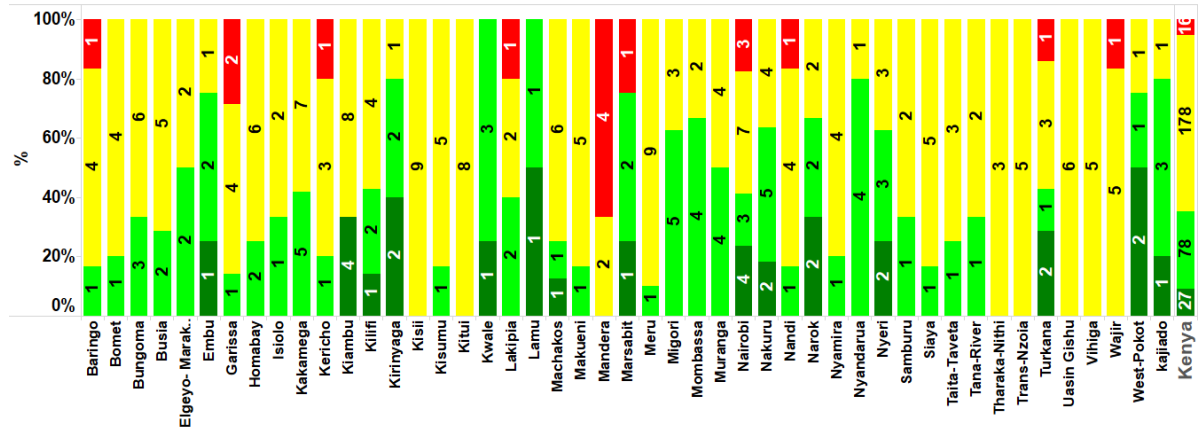
Figure 2



Legend: Penta 3 Coverage
■ <50 ■ 50 - 79 ■ 80 - 100 ■ >100

Figure 3

Number of Sub-Counties in a County By Coverage of Penta 3:
2015



Data source: Kenya DHIS as of 11 February 2016

Legend: Penta 3 Coverage
■ <50 ■ 50 - 79 ■ 80 - 100 ■ >100

Figure 4-Map: Distribution of under-vaccinated children by County

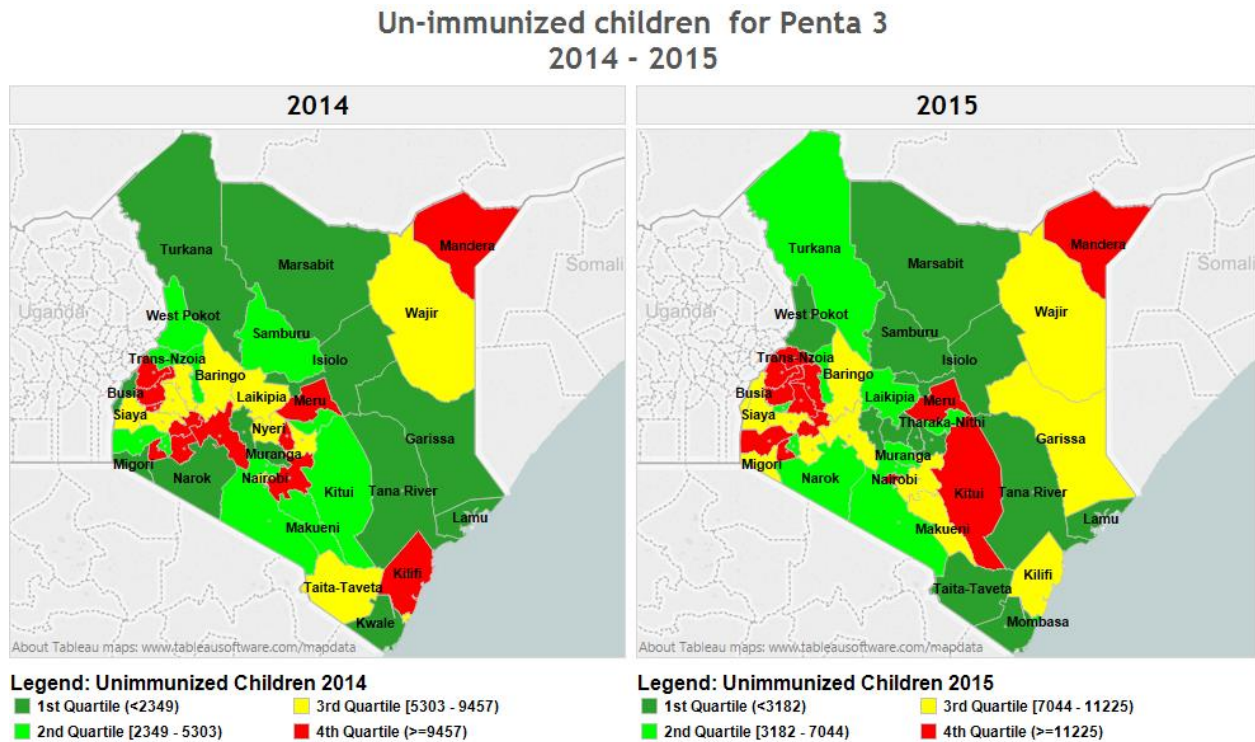


Figure 5

Number of Sub-Counties in a County By number of Un-Immunized Children for Penta 3: 2015

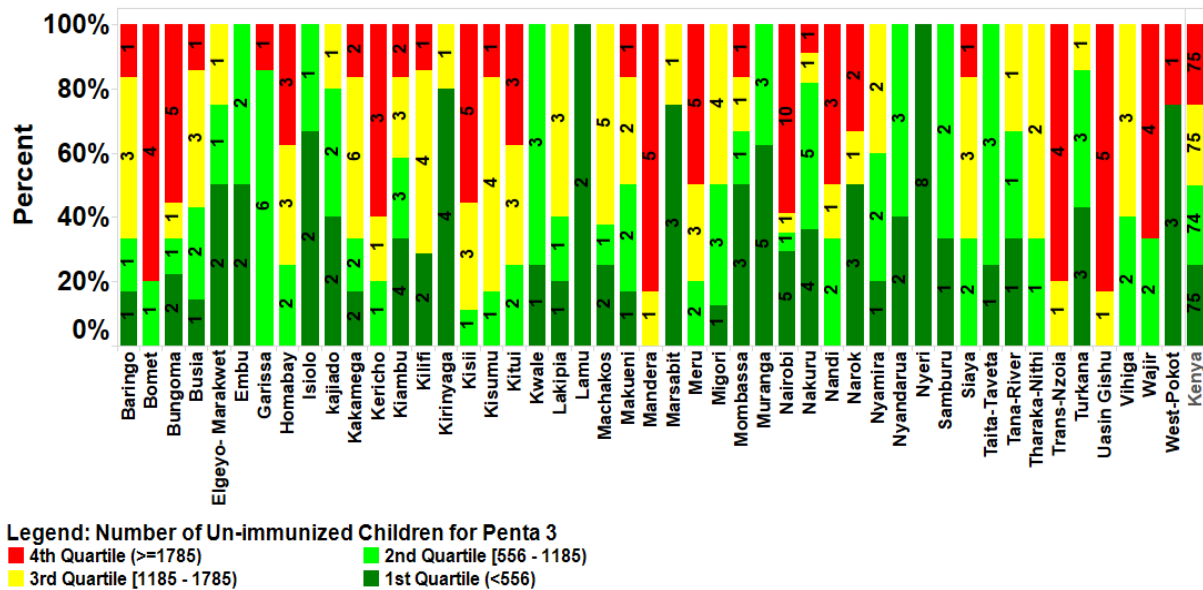
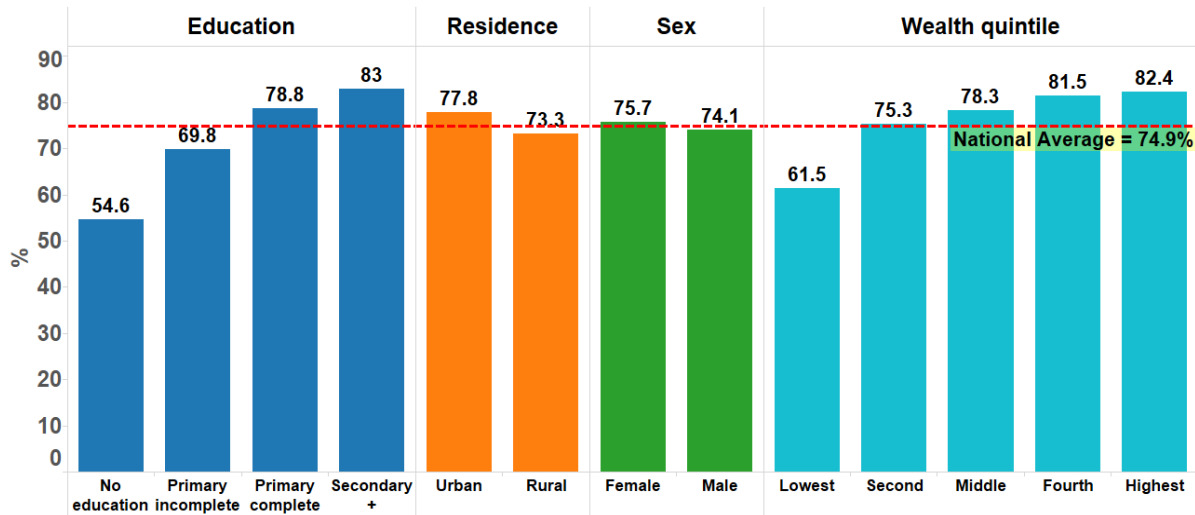
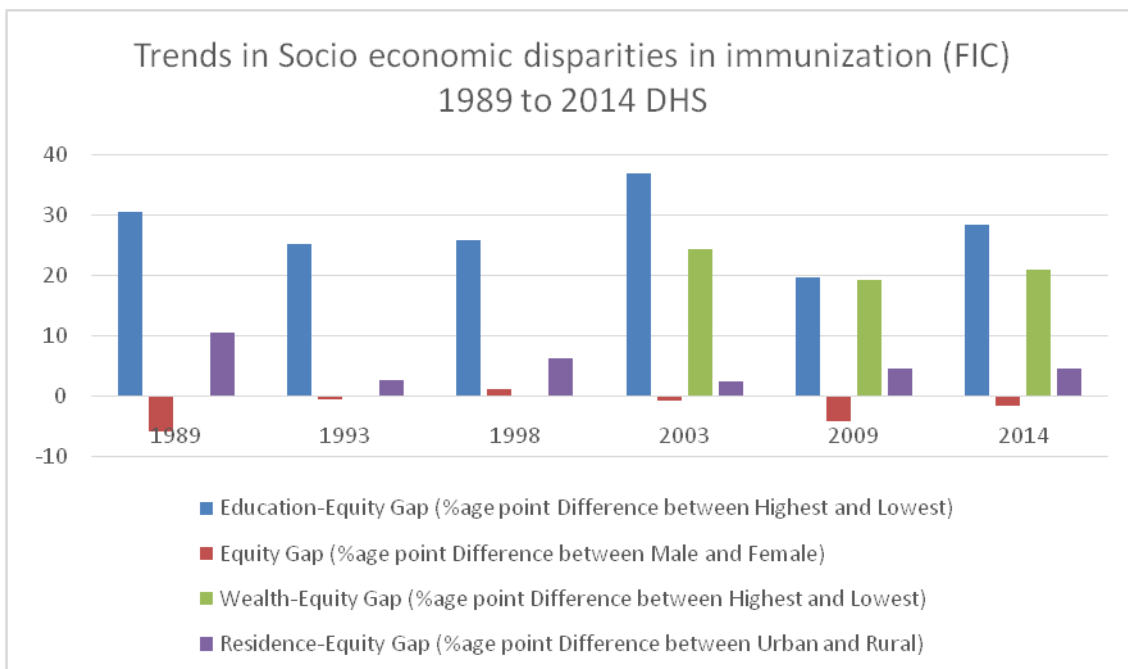


Figure 6: Percentage of Children Fully Immunized by socio-economic characteristics



Source: Kenya Demographic and Health Survey (KDHS) 2014

Figure 7



Data management, monitoring and evaluation

Kenya through the Ministry of Health has adopted DHIS 2 web based platform tool where immunization data is reported among other health sector indices. It is managed by the Unit of Health Information Systems within the Ministry of Health.

The Routine immunization data collected by health facilities is transmitted monthly to the sub-county using standardized immunization tool (MOH 710). At the sub counties the data manager aggregate data from all health facilities within the catchment areas and subsequently upload electronically to DHIS2, the server for the (DHIS2) is hosted at the Ministry of Health, unit of Health Information System which controls and gives access rights to specific officers that allow them to access the information. The DHIS2 consist of data elements on routine immunization including indicators and vaccine stock data. Demographic data in DHIS2 is however inaccurate posing challenge in analysis of key program data. The country utilizes surveys and studies including Kenya demographic and health surveys (KDHS2) to generate additional information to inform decision making. The last DHS was conducted in 2014 and Key Indicators Report is available.

County governments are responsible for the generation of county relevant reports, printing of county tools and entry of the data into the DHIS2. Following devolution of health services, reporting rates (timeliness and completeness of reports) declined from 100% to <90% in the year 2013/2014 but increased to 99% in 2015 following intense engagement with county staff. Data quality however remains low due to inadequate support supervision, non-implementation of data quality self-assessment and stock out of reporting tools in most health facilities. Even when NVIP has printed some tools using NVIG grants, the county have delayed in collection and distribution due to lack of financing by the County governments.

The 2014 KDHS results showed low immunization coverage and higher dropout in children's whose mothers are not educated and the lowest wealth quintile. The discrepancy between routinely collected administrative data and surveys may be as a result of under-reporting and higher denominator than the actual.

Routine and survey data are analyzed at national level and shared with immunization partners and counties. This practice is however rarely done at county level due to insufficient financial and technical support. There is need to improve data availability, quality and use for decision making at decentralized levels through implementation of the national data quality improvement plan which has been recently finalized and integrated in the Gavi HSS.

The National Immunization Program is currently scaling the use of a web based vaccine stock management tool (SMT) to all sub-counties to manage logistics. This is expected to improve visibility for vaccines at National level. Plans are underway to link the vaccine stock data with coverage data in DHIS. This data, like the DHISII is cross sectional, and not transactional, and may suffer from a lack of completeness and on-time reporting, limiting the utility of the data for stock planning and management.

Demand Generation and CSO Engagement

The Advocacy Communication and Social Mobilization (ACSM) Sub-Committee within the MoH is responsible for coordinating and providing technical support and leadership on social mobilization, communication and advocacy activities related to EPI. All sub-counties have health promotion officers who are responsible for social mobilization and communication. There is a strong need for capacity building of Health Promotion Officers, county immunization champions and CHVs to enable them for county & sub county specific communication interventions for demand generation in community for immunization services. All Counties have functional multi sectoral ACSM committees. Majority of the ACSM committees do not have comprehensive communication plans for Routine Immunization. There is therefore need for Communication Technical Assistance at county and sub county levels for conducting ACSM Rapid Assessment in four selected low performing counties for assessment of communication needs and then based on the findings of rapid assessment and desk review of all immunization KAP surveys & other studies already conducted to develop and implement county specific communication plans including component of risk communication. The County and sub county ACSM committees are spearheaded by Health Promotion Officers with representation from health stakeholders and partners.

Through increased engagement with stakeholders, especially religious leaders and immunization champions, vaccine hesitancy has declined. There is however, still need to map hesitant groups and key stakeholder and to increase engagement with health professionals and civil society to enhance their understanding of the immunization program strategies and challenges

Evidence shows that around 94% of care givers appreciate the benefits of immunization, which has

contributed to less vaccine resistance, but there is a limited knowledge of diseases prevented by the vaccines and the need to complete immunization schedule. There is therefore need to still increase engagement with health professionals and civil society to increase their understanding of the immunization program strategies and challenges. There is also need to engage the private sector through public private partnerships in a bid to supplement our demand creation efforts.

In Kenya, Community Health Volunteers (CHVs) and village leaders are the frontline workers for social mobilization. Communication has received limited attention by the EPI program due to funding constraints. In addition, ACSM has previously been handled as a single entity rather than an integral part to all the immunization programming during routine immunization and SIAs. ACSM has leveraged on the mass media and health promotion unit's social media digital platforms such as Facebook, Twitter, WhatsApp to disseminate information in Kenya especially during mass vaccination campaigns. It was also realized that use of SMS mode of communication with clientele resulted in great penetration and demand generation during the 2016 measles rubella campaign. Going forward, it would definitely be worthwhile and investment to add this form of communication to routine immunization as we also think around ways of making the service more affordable through our popular mobile service providers.

Community engagement and involvement needs to be strengthened to improve demand for and utilization of existing EPI services. The school health strategy of mobilizing children to reach families with key messages and for defaulter tracing during campaigns has been successful and needs to be scaled up also for routine immunization. The piloting of nomadic strategy in Turkana which tracks children under one year has demonstrated there is a huge population of children not vaccinated. Mapping and targeting these population groups will significantly contribute to overall immunization coverage.

Mobilization of 47 county polio survivors as champions for immunization is another success story which needs to be documented and scaled up. Ambassadors played a key role in addressing rumors on safety of polio, TT and MR vaccines. There is need to facilitate the immunization champions for effective advocacy and community mobilization. The country needs to strengthen the risk communication plan and capacity to address rumors related to immunization. Narrowing the gap between community and service utilization needs to be strengthened through focused community participation and engagement with health providers. Valuable lesson learnt from Polio SIAs will be effective in strengthening routine immunization programming. For example, the community dependency on door to door vaccination services has led to some extent, community reluctance to visit facilities for routine immunization services.

Health NGOs Network Coordinates Health CSOs in Kenya and has a membership across all counties in Kenya. The platform is represented in the immunization working group. CSOs play an important role in mobilizing communities for immunization services, sustaining community awareness on immunization, experimenting innovative approaches to service delivery and contributing to health systems strengthening at community level. CSOs play a key role in delivering services, enhancing the capacity of communities to demand services as well as carrying out advocacy work at the community level to increased immunization uptake. The CSOs work with all levels of Government and have a strong presence at the county level.

There is need to leverage on past experiences of CSOs at county level to achieve immunization objectives, especially due to the integral role played by a number of FBOs who operate health facilities that offer immunization services. Limited funding resources have posed a challenge towards continued service delivery by CSOs on immunization issues. The need to build communication and advocacy capacity, at sub-county level is critical, especially on Advocacy for allocation of county resources and reporting/monitoring of routine immunization communication activities.

Vaccine supply chain and cold chain management

The Kenya vaccine cold chain is made of 1 central vaccine store located in Kitengela. Below this level are 9 regional stores in Nairobi, Mombasa, Kisumu, Nakuru, Eldoret, Garissa, Meru, Kakamega and Nyeri. These regional stores hold vaccines for the sub county stores. There are 288 sub county vaccine

stores which serve over 6169 facilities. The National Government is responsible for managing the National and regional vaccines stores including vaccine procurement while the sub-county vaccine supply chain is managed by the county governments. County governments also take the responsibility of providing injection devices for administration of traditional vaccines. Gavi funded syringes are cleared, received and distributed by the National vaccines and immunization program (NVIP). The program outsources the distribution of vaccines from national to regional depots through a well-managed contract. From this level, counties plan pick-up of vaccines to their respective sub-county stores. Frequency of collection is usually dependent on storage capacity. NVIP has been engaging KEMSA for storage and distribution of injection devices to the sub-county store over the years. However, since KEMSA became semi-autonomous and with the program not getting any allocation for operations and maintenance, this is becoming increasingly difficult. Procurement of syringes at county level is also erratic hence, bundling of vaccines and injection devices is not done.

The national and 3 regional stores benefitted from the JICA project and have ample dry storage space dedicated to immunization supplies, while the other 5 vaccines regional stores are housed within KEMSA warehouses where capacity for storage of immunization syringes is inadequate and not guaranteed due to other bulky supplies competing for the same space. Hence injection devices have always been transported directly to the sub-county stores. Through continuous advocacy with government leadership the program is positive of improved budgetary allocation to cater for both vaccines and distribution costs.

Currently, the Ministry of Health outsources clearing and distribution of vaccines and related items from the national store up to regional store only and this has improved efficiency in clearance, stock availability, and management of the supply chain at the national and regional store level.

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

Kenya conducted an equipment inventory in 2011. This inventory was updated in 2015 and 2016. Between the inventory periods, the number of immunizing health facilities and cold chain equipment has increased. With support from the German government through KFW and UNICEF the national level procured equipment including spare parts and supported training of 47 METS and repairs of non-functional cold chain equipment. Several county governments have also procured EPI fridges. This support contributed to reduction of proportion of non-functional equipment from 840 (17%) in 2011 to 563 (8%) in 2016. Kenya now has more equipment operating on electricity and the number of Solar fridges has doubled. In addition, 90 immunizing facilities with electricity lack cold chain equipment while 1336 require replacement. The NVIP has developed a 5-year Cold Chain Expansion and Rehabilitation Plan (CCERP) that will guide investment in cold chain. To finance the plan, the MOH will enhance its advocacy activities with county leadership and immunization partners, as well as mobilize resources for CCE through Gavi HSS and CCEOP. Application for Gavi support through the CCEOP was submitted in September 2016. The table below highlights changes in status of cold chain equipment between 2011 and 2016.

Table: Status of cold chain in Kenya (2011 and 2016)

	Number of HF	Number of Equip	Number of HF without EPI fridge	Elect coverage	Non Functional (%)	PQS-PIS (%)	Non EPI	Solar
2011	5305	4946	13%	57%	17%	85%	15%	236
2016	6911	7042	18%	70%	8%	79%	21%	456

There are several challenges with the current vaccine supply chain mainly due to inadequate technical and financial capacity. A program audit conducted by Gavi in 2015 pointed towards a weak supply chain system. This included poor inventory records, non-adherence to the FEFO principle, lack of maintenance of buffer stocks across levels, periodic stock outs etc. In particular, for the period between 2013 and 2015, there were significant discrepancies in stock records. 580,000 doses of PCV could not be accounted for while almost an equivalent number of Penta vaccine was in excess. Following the audit, an analysis of PCV transactions made during this period was done to reconcile the figures. In addition, the Ministry is working closely with CHAI, UNICEF and other partners to strengthen EVM systems and practices.

HR capacity to manage vaccine depots remains a challenge. At national level there have been efforts to improve efficiency, including consideration to merge Nairobi and Kitengela stores to ease staff shortage. Currently, there's one officer managing each depot. Merging the two stores will slightly improve the current situation. An additional senior supply chain officer has also been deployed to the CVS. Regional stores are managed by county and KEMSA staff who are not directly answerable to NVIP, and can be redeployed any time. Going lower, the sub-county stores are managed by EPI nurses some of which are new to the program. There are plans to address any capacity gaps through trainings, supervision, and development of job aids through the Gavi HSS grant. Through 2015 Gavi TCA, UNICEF will provide consultant to support the EPI program overcome some of the challenges.

Availability and use of standardized stock management tools, both paper and electronic based, has not been satisfactory. Consequently, vaccine stock movements are not recorded and monitored systematically at all levels. Challenges with internet connectivity and general IT support have also greatly affected the quality of stock management data at national and regional storage points, resulting in huge discrepancies between the two systems. Currently UNICEF and CHAI are supporting MoH to better monitor vaccine utilization by rolling down the electronic SMT up to sub-county stores, revision and printing of tools, development of SOPs, enhancing the capacity of staff at regional and county level as well as supporting the government to implement 2013 EVMA recommendations. To date, 56 sub-county stores in 7 counties are using the Web based Stock Management Tool.

There is need for continued technical support for the program to rollout SMT, improved vaccine visibility, and institution of better good warehousing practices.

Financing of Immunization services

In the current financial year (2015/16), the government has allocated US\$1.5 billion for Health from Domestic resources. This reflects an increase of 40% compared to 2012/13 FY. A total of US\$ 845 million was allocated to the 47 Counties. The largest percentage of this budget however goes to personnel costs (73%). Health spending has remained at 7% of total Government Spending.

The Government of Kenya funds procurement of all the traditional vaccines (including storage and distribution) and co-finances with Gavi for the new vaccines (Penta, PCV, YF, Rota). Data from UNICEF supplies division indicates that a total of US\$ 56,079,628 was spent on vaccine procurement in 2015 with government contributing US\$5,149,176. There has been significant increase in allocation to the EPI program from the national Health budget with US\$ 7.03 million allocated in 2016/17 budget compared to US\$ 3.88 million in 2013/14. This allocation is for procurement of vaccines and not for operational costs. There is therefore a need for continuous advocacy for immunization financing including financing for operational costs. The table below summarizes a 4 year forecast of financial requirements for procurement of vaccines and injection devices.

	FY 2017 July '16 - June '17	FY 2018 July '17 - June '18	FY 2019 July '18 - June '19	FY 2020 July '19 - June '20
Traditional Vaccines:				
BCG	1,556,979	1,603,688	1,651,799	1,701,353
BOPV	1,880,164	1,936,569	2,105,480	2,168,645
Mea/MR (from 2017)	4,262,254	5,921,798	6,099,452	6,282,436
TT	662,632	682,511	702,986	724,075
Gavi Co-Financing:				
Pentavalent	805,400	692,900	648,180	761,319
PCV	1,801,450	1,526,008	1,427,517	1,676,691
RV	805,950	685,918	641,647	778,081
YF	18,900	7,491	7,017	8,251
HPV	0	0	459,875	583,477
Injection Devices+Safety Boxes:	1,020,467	1,051,082	1,082,614	1,115,092
Total Vaccine Supply	12,814,196	14,107,964	14,826,567	15,799,420
Proposed VII Ceiling	4,500,000	4,500,000	4,500,000	4,500,000
Required VII Turns	2.8x	3.1x	3.3x	3.5x

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

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

	FY2012/20	FY2013/20	FY2014/2	FY2015/20
National Budget (GOK)				
Traditional infant vaccines	2,395,610	-	-	2,903,754
Other vaccines (Non EPI)	-	1,497,860	145,517	2,323,003
GAVI Co-Financing	4,615,869	2,724,000	3,018,176*	3,714,079
Operations and maintenance	1,110,964	-	38,064	1,161,502
Total GOK	8,122,444	4,221,860	3,201,757	10,102,338
Gavi Grant	45.2M	39.7M	26.2M	69.2M

*includes co financing for Rota

Source: MoH 2013, using exchange rate of 1USD = 100 Kes

Expenditure trends on vaccine procurement (UNICEF SD)

	2010	2011	2012	2013	2014	2015
GAVI	27,601,658	54,924,881	40,455,583	33,187,185	31,363,796	50,930,452

Government (Traditional and Co-financing)	2,658,878	5,294,257	6,251,640	3,631,641	4,831,900	5,149,176
Total	30,260,536	60,219,138	46,707,223	36,818,826	36,195,696	56,079,628


Trends in Domestic financing for health and National Immunization Program (NVIP)

Year (US\$)	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Health Budget	1,010,180,000	1,010,180,000	362,180,000	473,620,000	591,840,000	602,700,000
NVIP Budget	8,280,000	8,280,000	3,880,000	3,880,000	4,100,000	7,030,000
NVIP Budget /Health Budget	0.82%	0.82%	1.07%	0.82%	0.69%	1.17%

The country continues to experience delays in meeting MOH/UNICEF VII (Vaccine Independent Initiative) agreement and Gavi co-financing obligations. Alignment of Gavi and government of Kenya fiscal year will help address delays in co-payment. A new MOH-UNICEF VII plan that has been finalized and allocates more funds for Kenya will further address timely financing for vaccine procurement. Underfunding for immunization at county and national level still remains a major challenge. Ongoing advocacy efforts with members of parliament will further contribute to addressing pending challenges. The MPs have committed to support the EPI program mobilize additional funding through annual national budget, explore alternative financial mechanisms to achieve UHC and advocate with county governments to support immunization program. UNICEF has also held advocacy meeting with Governors and rallied them to support immunization. These efforts will help sustain financial support for the program.

Expenditure tracking remains a major challenge for Kenya and there is need for a mechanism to address this gap. This should be extended to tracking funding from partners.

3. GRANT PERFORMANCE AND CHALLENGES (maximum 3-4 pages)

 Describe only what has changed since the previous year's joint appraisal. For those countries conducting the joint appraisal 'update', only include information relevant to upcoming needs and strategic actions described in section 5

3.1. New and underused vaccine (NVS) support

3.1.1. Grant performance, lessons and challenges

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: programmatic performance of each vaccine programme against approved targets and planned activities, including progress and bottlenecks in implementation; actual versus planned financial expenditure, associated challenges, proposals for using unspent funds, and complementarity between all cash grants]

Performance of Gavi supported vaccines:

Through Gavi support, Kenya has maintained the following new and underutilized vaccines in routine

immunization system: PCV10, Pentavalent, Rota Virus, IPV and Yellow Fever. The table below summarizes coverage against target by antigen

Vaccine	Target Coverage	2015 Coverage	June 2016 Coverage
Pneumococcal 1	90%	81%	80%
Pneumococcal 3	90%	75%	73%
Pentavalent 1	90%	81%	80%
Pentavalent 3	90%	75%	74%
Rota Virus 1	90%	75%	76%
Rota Virus 2	90%	66%	68%
Yellow Fever*	90%	20%	3%
IPV	90%		57%

* Yellow fever coverage is as per the target population in the two counties

Kenya has faced challenges in availability of YF vaccine due to global constraint. The DHIS only began capturing IPV coverage as from March 2016

The overall national coverage depicted in the above table indicates a stagnation of coverage rates from 2015 to date.

Challenges affecting achievement of immunization coverage targets:

Majority of communities in Kenya understand the benefits of immunization and are willing to present their children for vaccinations. There is minimal resistance to vaccination. Since 2013, the health sector in Kenya has faced several challenges linked to devolution. The EPI program is slowly recovering from these challenges but a lot remains to be done to protect the program and reach more children with lifesaving vaccines.

The following are the major challenges faced by the program that affected achievement of planned immunization coverage target of 90% across all:

- (i) Stock out of injection devices and traditional vaccines due to inadequate and delayed financing
- (ii) Limited access to vaccination by hard to reach populations (nomads) due to under funding for outreach and mobile services by counties
- (iii) Stock out of vaccines at HF due to weak supply chain management especially at sub-national level
- (iv) Insecurity in Northern Kenya especially Mandera county. This has contributed to this county reporting 35%
- (v) Inappropriate service delivery schedules especially in major urban settlements.
- (vi) Financial access especially in urban informal settlements of Nairobi where majority of HF are private and charge a fee
- (vii) Minimal support supervision, regular data review meetings and micro planning at sub-national level due to financing constraints
- (viii) Supply constraints for some vaccines e.g. IPV and Yellow Fever

New Vaccines Introduction and Campaigns

(i) Introduction of the Inactivated Polio Vaccine (IPV):

With support from Gavi, Inactivated Polio Vaccine (IPV) was introduced into routine immunization in November 2015. IPV introduction had been planned for July 2015 but was delayed to November 2015 due to global supply constraints. Despite the delay in introduction, the national rollout was successful and current coverage stands at 57% (DHIS, 2016). This may be low due to data quality issues and delayed introduction.

Successes:

- a) Effective Advocacy, Communication and Social Mobilization for IPV introduction leading to sensitization of the communities on polio eradication efforts and the importance of the inactivated polio vaccine. This has contributed to high acceptance of IPV by the health care workers and care givers.
- b) Training of health care workers on IPV and refresher training on other RI vaccines
- c) Printing of additional reporting tools including vaccine ledger books

Challenges:

- a) Delayed disbursement of VIG funds led to delays in the national rollout
- b) Global constraints in the supply of IPV exacerbated the delays in introduction of IPV into RI
- c) Sustainability of procurement of IPV by Government (Gavi Board has currently approved Gavi financing of IPV doses up to 2018 only) poses a challenge due to limited Government funds

Next steps:

- a) Conduct post introduction evaluation (PIE) for IPV in November 2016 and utilize the opportunity to identify and address challenges in RI

(ii) tOPV to bOPV Switch

In line with the polio eradication end game strategy, Kenya committed to switch from trivalent OPV to bivalent OPV and this was officially done in April 2016.

Successes:

- a) No tOPV in the supply chain after the switch and Kenya marked as successfully validated in May 2016 by the National Switch Validation Committee
- b) Mapping of waste disposal sites/incinerators nation wide
- c) Developed waste management protocol that guided subsequent MR vaccination campaign

Next steps:

- a) Continued surveillance for presence of polio virus

(iii) Measles Rubella campaign

Kenya successfully conducted the MR campaign in May 2016 with over 19 million children aged between 9 months and 14 years immunized. The campaign had been postponed after discussion with partners and MOH to ensure a high quality campaign. Administrative coverage was 101% while the coverage survey preliminary results indicate a coverage of 95%

Successes:

- a) MR training used as an opportunity to target training of Health care workers
- b) Successful micro-planning at ward level conducted in March 2016 prior to the MR campaign and is being used in planning for routine immunization and improving cold chain capacity.
- c) Successful integration with neo-natal tetanus campaign in select counties
- d) High administrative coverage of MR of 101%

- e) Implemented waste disposal protocols developed during tOPV switch leading to overall success in waste management

Challenges:

- a) Resistance from a few religious groups
- b) Lack of funding for Congenital Rubella Syndrome (CRS) tracking. The country is therefore not able to determine the effect of MR on CRS

Next steps:

- a) Leveraging on micro plans developed during MR to carry out RED approaches and strengthen routine immunization at the smallest administrative level
- b) Implement CRS tracking
- c) Scale up of waste disposal protocols for vaccine and vaccine related waste.
- d) Introduce MR into routine Immunization (funded by GOK, not Gavi) in October/November 2016. Funds for vaccine purchase have been factored in the budget.

Key lessons learned to inform future routine vaccine introductions or campaigns

- a) The importance of using a NVI and campaign as an opportunity to update healthcare worker knowledge through training, build on the cold chain and improve on micro-planning processes
- b) Led to increased utilization of other routine immunization antigens as a result on new vaccine introduction

Key implementation bottlenecks and corrective actions, along system components

- a) Knowledge gap on basic EPI among health workers especially clinicians was noted. The program leveraged on new vaccine introductions to update health worker EPI knowledge. Capacity gaps still remain, these will be addressed in the Gavi HSS grant and Technical Country Assistance. Activities planned include: training of health care workers and their managers at county, sub-county and facility level; and orientation of other professionals not regularly providing EPI services.
- b) Lack of a robust and fully functional health information system – support was provided to DHIS by printing reporting tools. There is need to improve data analysis, data quality and use of data for decision making
- c) Inadequate involvement of key leaders in immunization and limited effective governance and oversight of program at sub-national level – advocacy to the key decision makers at all levels was conducted eliciting robust support for the program
- d) Limited health financing allocation particularly towards immunization – advocacy to treasury and county governments and funding from HSS and CCEOP to improve the immunization system
- e) Service delivery constraints – limited outreaches and linkages with community

3.1.2. NVS future plans and priorities.

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: for existing vaccines - reasonableness of targets for next implementation year, plans for any changes in presentation or type, risks to future implementation and mitigating actions; for new applications – any expected future applications (include in table 1 above), emerging new priorities for the national immunization programme]

The country requests renewal of support for the following vaccines through 2018, as submitted in the Gavi country portal:

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

Emerging new priorities for the national immunization programme

Kenya plans to strengthen the role of ICC and KENITAG and advocate for increased funding for immunization.

The programme targets to improve supply chain and cold chain management to improve efficiency.

Development and implementation of county-specific communication plans is planned for demand generation

Promotion and scale-up of REC strategy is also a priority

In addition, the programme plans to enhance data management and surveillance activities.

Kenya is currently working on the introduction of Measles Rubella into the routine immunization program in November 2016.

In addition, the country is in the process of planning for HPV national roll-out in 2018 using a multi-cohort approach in the first year targeting girls aged between 9 – 13 years.

Lastly, the country is also in the process of piloting Influenza vaccine introduction to children using a tentative schedule of 6, 7 and 18 months. This is currently in the proposal stage at the Ministry of Health and with CDC.

3.2. Health systems strengthening (HSS) support

3.2.1. Strategic focus of HSS grant

[Comment on the extent to which the HSS grant contributes to improve coverage and equity in access to immunization, and how it helps to address the technical, health systems and financial bottlenecks that might jeopardize the sustainability of these gains. See guidance document for more details]

Kenya applied for the 18.4 million USD Gavi HSS cash support in January 2016.

The clarification review panel (proposal was reviewed by IRC (March 2016) and later by the CRP) (feedback received July 2016). The CRP has approved HSS application of USD 18.4 Million pending recommended modifications. In addition, Gavi approved the release of the remaining ISS funds of USD 2,203,140 which will be made available to augment HSS. These approvals are subject to minor budgetary changes.

By addressing the priority bottlenecks, the HSS proposal aimed 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 sub-national levels by 2019
- 4) To strengthen immunisation data management and information systems for timely decision making at national and sub-national level by 2019

Degree of participation of key stakeholders in the implementation of the HSS proposal, including civil society organizations

The development of the HSS proposal was a consultative process that involved different stakeholders including civil society organizations such as HENNET as a CSO umbrella body, technical partners and bi-lateral funding agencies. Overall, there has been increased participation by CSO's not only in HSS proposal development but also in NVIP.

3.2.2. Grant performance and challenges

[Comment on the relevant bolded areas listed in the table in this section of the guidance document, e.g.: achievements of targets and intermediate results; actual versus planned activity implementation and financial expenditure; use of PBF reward and budgets/plans; degree of participation of key stakeholders in implementation of HSS proposal; implementation bottlenecks and key challenges regarding financial management of HSS grant; compliance with data quality and survey requirements]

Kenya currently has no active HSS grant.

3.2.3. Describe any changes to HSS funding and plans for future HSS applications

[Present the rationale for a new tranche of HSS funds (and the associated amount as per table in section 1) or no-cost extension, or any planned changes in terms of re-allocation or reprogramming]

Kenya currently has no HSS grant but the country applied for the Gavi HSS cash support in January 2016. This application was approved with recommendations for some final modifications. The country will make the necessary modifications to the application prior to receipt of HSS funds.

3.3. Transition planning (if relevant)

[Comment on all bolded areas listed in the table in this section of the guidance document, e.g. progress of implementation of planned activities; implementation bottlenecks; changes required to the transition plan for coming years, including rationale and costing/proposed financing]

Kenya has entered the preparatory transition phase (January 2016). The co-financing has been aligned with Kenya's fiscal year to help timely payments. Kenya's co-financing contribution/obligation currently stands at 6% and is expected to increase to about 11% contributing about \$4.5 million by 2020. With current projections, Kenya is expected to enter the accelerated transition phase in 2021. To prepare effectively for transition through these phases, Kenya's transition plan will reflect activities to be conducted to sustain the gains of Gavi investments and provide sustainable financing for the immunization programme. These include:

- Conducting transition assessments focusing on key areas of immunization performance, financial sustainability, institutional apparatus and capacity, of the national immunization programme within the broader health system framework.
- Developing plans (including financial sustainability plan), strategies & actions to address/mitigate the gaps and/or weaknesses found in the assessments.
- Actively engaging Gavi and Alliance partners throughout the transition process to identify potential bottlenecks for successful transitioning and support for interventions that will mitigate them.
- Engaging stakeholders (governments, parliamentarians, CSOs, partners, donors, private sector etc.) to advocate for sustainable financing and resources for national immunization programme. A joint Gavi-Global Fund workshop was held in late July 2016 to sensitize Parliamentarians on the importance of sustainable domestic financing for HIV, TB, Malaria and Immunization.
- Mobilizing financial resources from government, partners, donors, etc. to support the immunization programme
- Reviewing/updating the cMYP to reflect the additional obligations and provide for alternative sources of sustainable financing
- Leveraging Gavi support/facilitation to continue to gain access to vaccines at affordable prices as the country transits through the transition phases
- Aiming to utilize Gavi's "grace year" in the accelerated transition phase to apply for Gavi new and underused vaccines support (NVS).
- Monitoring transition plan through Joint Appraisal process.

Comprehensive guidance on how to develop this transition plan will be supported by Gavi.

3.4. Financial management of all cash grants (e.g. HSS, VIG, campaign operational cost grant, transition grant)

[Comment on the bolded areas listed in the table in this section of the guidance document, e.g.: cash utilization performance and financial capacity constraints; modifications to financial management arrangements; major issues arising from cash programme audits or monitoring review; degree of compliance with Financial Management Requirements]

By December 2015, Kenya had cumulatively received a total of USD 30,746,643 cash support (HSS, INS, ISS, HPV, MR SIAs and VIGs).

The VIGs for Rota, IPV and MR vaccines and financial support for HPV demo has been channelled through UNICEF due to outstanding accountability concerns with previous grants channelled through the government.

In July 2015 Kenya received USD 12,332,500 from GAVI as operational support for measles rubella supplementary immunization activities. A further USD 2,520,500 was also received as MR and IPV vaccine introduction grants. It was not possible to conduct MR SIAs in November 2015 as earlier planned and the activity was pushed forward to May 2016 to enable the country adequately prepare to conduct quality campaign. The introduction of MR into routine immunization schedule is set for November 2016. Training for health workers on MR and other components of EPI have been conducted to support introduction into RI. UNICEF is currently still holding USD 257,469 from MR VIG. This may however change as some payments to suppliers are still being processed. The amount will be utilized to undertake social mobilization, advocacy, support supervision and monitoring as part of introduction activities to raise coverage for MCV 1 and 2. A total of USD 4,191.91 is the current balance from previous NVIG for Rotavirus vaccine and IPV. These grants have however expired and the reports shared with Gavi.

Kenya had some outstanding audit issues relating to previous HSS and ISS support. To this effect Gavi Audit team carried out an extensive visited audit of both the HSS and ISS cash grant support between October 2015 and March 2016. The audit indicated that there was inadequately supported expenditure of USD 1,604,283 which has to be repaid back to Gavi. The Ministry of Health has committed to make the repayment by 30 June 2017 in two installments of 50% (15 October 2016 and 30 March 2017). A further USD 254,748 in unused program cost in the Ministry and treasury accounts will be repaid to Gavi (the original deadline for this was 30 June 2016).

Overall programmatic capacity to manage NVS grants

Following the PCA and Gavi audit, the MoH with support from WHO and UNICEF is improving its capacity to manage cash grants from Gavi such as NVS and HSS. Discussions are ongoing with Gavi to finalize GMA.

4. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

[Status of top 5 prioritized strategic actions from previous joint appraisal and any additional IRC or HLRP recommendations (if relevant)]

Following 2015 Joint Appraisal, Gavi provided support to Kenya in the tune of US\$ 2,319,734.26 for technical support (Gavi TCA). The funds were provided through UNICEF, WHO, CDC and World Bank. Implementation is ongoing. The funds were disbursed in April 2016. Implementation of some activities has delayed due to the March and April Polio campaigns and May MR campaign. Below is summary of status of implementation of key recommendations.

Actions	Status	Remarks
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<p>1. Improve governance and coordination at all levels:</p> <p>a) Clearly define immunization roles and responsibilities at the national and county level.</p> <p>b) Establish a coordination mechanism for immunization between national and county Governments</p>	<p>National program has held 3 advocacy meetings with County governments. Continued support will be provided through HSS grant and other partners especially UNICEF and CSO.</p>	<p>On track</p>
<p>2. Mobilization of financial resources for immunization at national and county levels:</p> <p>a) Develop national and county levels costed multi-year and operation plans</p> <p>b) Develop advocacy tools and video for prioritization of immunization programmes</p> <p>c) High level advocacy to leadership (national and county) and private sector</p> <p>d) Multi-sectoral engagement</p> <p>e) National and county government to map and leverage on non-immunization resources/programmes to support immunization (Global fund, GFFHIV, Malaria etc....)</p> <p>f) Develop financial sustainability plan at the county level</p> <p>g) Develop proposal for funding using Gavi HSS funding platform</p>	<p>National MYP has been completed while development of County plans delayed.</p> <p>Gavi HSS proposal developed and approved by Gavi. Discussions ongoing on Grant Management arrangement and outstanding Audit and PCA issues.</p> <p>Advocacy on Increased domestic financing and alternative financing mechanisms through commercial financing and Trust Fund ongoing at National and Counties including parliament.</p>	<p>On track</p>

<p>3. County and Sub-County Capacity Strengthening</p> <p>a) Build capacity of county managers, on leadership, programme management, procurement, resource mobilization, advocacy and financial management</p> <p>b) Conduct operational level training for sub-county immunization managers and health workers in poor performing areas</p> <p>c) Orient CSOs on immunization</p>	<p>Will be supported through 2016 and 2017 TCA and Gavi HSS</p>	<p>Delayed</p>
<p>4. Reduce inequities in immunization coverage across and within counties:</p> <p>a) Identify low performing counties and develop county specific immunization improvement plans</p> <p>b) Roll out reach Every Child Strategy in targeted counties</p> <p>c) Conduct immunization equity analysis</p> <p>d) Identify strategies to improve MCV2 coverage (vaccination uptake in the second year of life)</p>	<p>Low performing counties identified, national broad analysis of inequities done.</p>	<p>Delayed</p>

<p>5. Strengthen immunization data collection, reporting, monitoring processes and use of information at all levels:</p> <ul style="list-style-type: none"> a) Review, finalize and implement data quality improvement plan b) Develop M&E framework for immunization programme c) Regular engagement with county immunization managers to review immunization and vaccine stock data to identify and address issues that contribute to poor data quality d) Address Immunization data flow challenges from the health facility, to county and to the national level e) Support immunization financing expenditure data tracking, use and reporting 	<p>National and county level support enhanced through WHO/CDC START program</p> <p>County level. Reporting rates have improved.</p> <p>Expenditure tracking is prioritized for 2017</p> <p>Completed data quality assessment following which a data quality improvement plan was developed</p>	
<p>6. Generate demand for vaccines and improve visibility of immunization among communities</p> <ul style="list-style-type: none"> a) Develop county specific social mobilization and communication plans b) Develop and implement Risk communication plan 	<p>Draft National communications plan available. Communications needs assessment for the 4 priority counties for 2016 is planned</p>	<p>Delayed</p>

<p>7. Improve and maintain efficient Vaccines supply and cold chain:</p> <p>a) Finalize and operationalize Cold chain replacement and maintenance plan.</p> <p>b) Roll out of the stock management tool to sub-counties</p> <p>c) Update and implement vaccine management guidelines</p> <p>d) Improve vaccine wastage monitoring</p>	<p>Cold chain Rehabilitation Plan finalized awaiting ICC approval; Stock Management tool rolled out to 11 counties with rest of counties to start implementing by December. 47 Medical Engineers Trained in maintenance; implementation of new temperature monitoring devices assessed with plans to address recommendations developed.</p>	<p>On Track</p>
<p>8. Evidence generation, surveillance and new vaccine introduction:</p> <p>a. Evidence generation to demonstrate burden of disease and impact of vaccines in Kenya</p> <p>b. Strengthen vaccine preventable diseases (VPD) surveillance and laboratory</p> <p>c. Operational research on priority issues affecting immunization programme</p> <p>d. Document challenges and best practices/approaches used to reach unimmunized children in Kenya</p> <p>e. Planning for introduction of new vaccines (MR campaign and routine introduction, HPV demo and national introduction)</p>	<p>MR Campaign Conducted successfully with introduction to RI in October/November 2016</p> <p>Support for Surveillance ongoing amidst funding challenges HPV national rollout planned</p>	<p>Delayed due to lack of adequate funding for surveillance</p>

5. PRIORITISED COUNTRY NEEDS¹

[Summarize the highest priority country needs and strategic actions that could significantly improve coverage, equity and financial sustainability; the timeline for completing the actions and the type of technical assistance needed if applicable – see guidance document for more details]

¹ Subsequent planning and discussions on Targeted Country Assistance will take place - detailed guidance on the process will be shared in May 2016.

Prioritized needs and strategic actions	Associated timeline for completing the actions	Does this require technical assistance? * (yes/no) If yes, indicate type of assistance needed
<p>Vaccine supply, cold chain and logistics</p> <p>a) Improve cold chain performance and temperature monitoring through refresher training on temperature monitoring and response by facility first responders at facility level.</p> <p>b) Improve supply chain data visibility for informed decision making: Roll out and follow up on utilization of SMT, ViVa and provision of report tools to sub-counties</p> <p>c) Promote efficiency and best practices in vaccine management. This will be done through:</p> <ul style="list-style-type: none"> a. Development and dissemination of Vaccine supply chain management SOPs b. HR capacity building on norms and standards of supply chain (reorder levels, min/max etc.) c. Development and implementation of the M&E Plan. <p>d) Carry out a follow up EVM Assessment 2017</p>	<p>a) Q1 2017 b) Q1, Q2 2017 c) Q1, Q2 – 2017 d) Q3 2017</p>	<p>TA required from UNICEF, CHAI, JSI, WHO</p>
<p>Coverage and equity in prioritized Counties</p> <p>a) Promote and scale up of REC Strategy focusing on reasons for poor performance</p> <p>b) Operational level training of sub-county immunization managers and health workers in poor performing areas</p> <p>c) Update, print and disseminate operational guidelines and job aids for immunization</p> <p>d) Develop tools for and implement supportive supervision</p> <p>e) Identify strategies to improve MCV2 coverage (vaccination uptake in the second year of life)</p>	<p>a) Q1-Q4 2017 b) Q 1-Q4 Jan 2017 c) Q 1-Q4 Jan 2017 d) Q 1-Q4 Jan 2017</p>	<p>TA required from WHO, UNICEF, MCSP</p>
<p>Demand creation for immunization</p> <p>a) Behavioral rapid assessment on immunization in focus low performing counties/sub Counties</p> <p>b) Assess immunization communication needs among special populations - mobile populations, slum settlement and other marginalized groups</p> <p>c) Implement County specific communication plans with component of risk communication, based on the findings of the rapid assessment</p> <p>d) Development of County specific Advocacy tools</p> <p>e) Build capacity County EPI Focal point persons, HPOs, CSOs and immunization champions to map and engage vaccine hesitant group</p>	<p>– Q1 – Q1 – Q1-Q4 – Q2-Q3 – Q2</p>	<p>TA required from UNICEF, WHO, CSOs</p>

<p>Data management and surveillance</p> <p>Data</p> <p>a) Establish mechanisms to capture relevant data on immunization financing</p> <p>b) Conduct training/mentorship of health workers and managers on data management</p> <p>c) Ensure immunization data tools are harmonized and appropriately distributed, along with relevant job aids</p> <p>d) Conduct annual reviews of data and set revised population targets</p> <p>e) Ensure linkages between vaccine stock data and necessary follow-up</p> <p>f) Comprehensive immunization programme review</p> <p>Surveillance</p> <p>g) Surveillance for new vaccines to determine burden of Vaccine preventable disease and impact of vaccines-rotavirus, IBD, CRS, MenA, HepB birth dose, Measles</p> <p>h) Develop vaccine safety strategy</p>	<p>a) Q1, 2017</p> <p>b) Q2 and Q4 2017</p> <p>c) Q1 2017</p> <p>d) Q1 Q2 2017</p>	<p>TA required from WHO, UNICEF, CDC</p>
<p>Planning coordination and governance</p> <p>a) Strengthening of ICC, Stakeholder meetings- National and County</p> <p>b) Advocacy with policy makers and parliamentarians for prioritization of immunization financing and bundling of vaccines with devices</p> <p>c) Update National and develop county multi-year plans for immunization</p> <p>d) Document challenges and best practices/approaches used to reach unimmunized children in Kenya</p> <p>e) Application for HPV national roll out; define county specific strategies</p> <p>f) Financial and technical support KENITAG operations to prioritize new vaccines looking at vaccine landscape and horizon taking into account financial sustainability and graduation of Kenya from Gavi support</p> <p>g) Define data requirements and tools to track immunization expenditure at national and county levels</p>	<p>e) Q1-Q4 2017</p> <p>f) Q2 2017</p> <p>g) Q3 2017</p> <p>h) Q1-Q2 2017</p> <p>i) Q2 2017</p> <p>j) Q1-Q4 2017</p> <p>k) Q2-Q4</p>	<p>TA required from WHO, UNICEF</p>

**Technical assistance not applicable for countries in final year of Gavi support*

6. ENDORSEMENT BY ICC, HSCC OR EQUIVALENT AND ADDITIONAL COMMENTS



This section does not need to be completed for joint appraisal update in interim years, instead the EPI manager is expected to endorse the joint appraisal report.

Brief description of how the joint appraisal was endorsed by the relevant national coordination mechanism	The Joint appraisal draft was circulated to Child Health ICC members followed by an ICC meeting that endorsed the Joint Appraisal Report.
Issues raised during debrief of joint appraisal findings to national coordination mechanism	
Any additional comments from: <ul style="list-style-type: none"> • Ministry of Health • Gavi Alliance partners • Gavi Senior Country Manager 	

7. ANNEXES



This section does not need to be completed for joint appraisal update in interim years. Please include the following Annexes when submitting the report, and any others as necessary

Annex A. Description of joint appraisal process (e.g. team composition, how information was gathered, how discussions were held)

On 14th July 2016, during the immunization TWG, teams were constituted to start the preparatory phase in handling various areas in the 2016 JA process. The teams were tasked to ensure they collate all the documents required for the JA, read through the previous JA and highlight the progress of the key areas of improvements brought out as per the 2015 JA. The teams constituted of members from the MoH- NVIP, MoH health promotion, Treasury (represented by the MOH accountants), WHO, UNICEF, MCHIP, HENNET, Kenya Red Cross, KANCO, CRS, JSI, CHAI, USAID, Micro-Nutrient and CDC.

The team later met on the 2nd to 4th of August for a preparatory phase to jointly review the recommendations of the previous JA, review guidelines for JA, assign tasks and responsibilities and develop a zero draft for the 2016 JA. During this process the following key documents were reviewed and utilized in developing the 2016 JA; JA planning guidance, JA reporting guidance, the JA template, CMYP 2015 document, KDHS 2014, The GAVI TCA, KHSSP 2014-2018, WHO-UNICEF JFR, PIE for measles 2nd dose and Rota vaccine 2015, EVM assessment of 2013, NVIP work plans and reports and NVIP field reports among others.

The Kenya Joint appraisal (JA) conducted between 8th and 12th 2016, reviewed the implementation, progress and performance of Ministry of Health immunization program in general. JA teams reviewed the country's health systems and immunization performance, challenges in immunization program, progress in implementing recommendations made during 2015 JA and identification of areas for targeted national investments in 2017. The JA teams then reviewed the funds, efforts, technical support and advice required to meet these goals and objectives.

The 2016 JA process involved the Ministry of Health and in-country partners as well as technical partners from outside the country. The partners involved in the JA were CDC, DFID, WHO (country, regional and HQ), Lions, Sabin, Gate Foundation, CDC, World Bank, UNICEF (Country, ESARO and HQ), GAVI secretariat. DHL was involved as part of a learning process to help identify supply chain visibility needs. The JA involved 3 days of reviewing country context and performance, reviewing the draft JA report. There was 1-day for field visits to 3 counties (Kajiado, Kitui and Nairobi) to provide the partners an opportunity to interact with the health system as well as interact with the communities that get immunization services from different areas. The field observations were then taken into account in the final JA process. The team provided feedback to the Principal Secretary for Health and UNICEF and WHO Country Representatives on the last day.

The final JA was then presented to the Child Health ICC for endorsement and ratification.

Annex B: Changes to transition plan *(if relevant)*

Changes proposed	Rationale for changes	Related cost (US\$)	Source of funding for amended activities	Implementation agency	Expected result