

Joint Appraisal report 2018

The italic text in this document serves as guidance, it can be deleted when preparing the Joint Appraisal (JA) report.

Gavi's support to a country's immunisation programme(s) is subject to an annual performance assessment. The Joint Appraisal (JA) is a key element of this performance review. It is an annual, country-led, multi-stakeholder review by the senior leadership of the MoH and its partners of the implementation progress and performance of Gavi's support to the country, and its contribution to improved immunisation outcomes.

Joint Appraisals require careful preparation. This includes:

- **By 15 May: Submission of the vaccine renewal request** on the country portal (including provision of end of year stock reporting, targets, wastage rates, etc.)
- **4 weeks before the Joint Appraisal:**
 - **Submission of required reporting documentation** on the country portal;
 - **Submission of HSS and CCEOP renewal request** (if new tranche needed), on the country portal including HSS budget for requested tranche;
 - **Gavi partners (WHO, UNICEF and others)** to report progress against their milestones and PEF functions on the partner portal.

Reporting requirements

The following reporting is required for renewal purposes and must be posted on the country portal 4 weeks before the JA:

- **Update of the grant performance framework (GPF)**
- **Financial reports, annual financial statements and audit reports** (for all types of direct financial support received)
- **Reporting on any campaigns/SIA conducted** (if applicable)
- **End of year stock reporting** (which is to be submitted by 15 May together with the vaccine renewal request)

Other required reporting information to be posted on the country portal 4 weeks before the Joint Appraisal includes:

- *Immunisation financing and expenditure information*
- *Data and survey requirements*
- *Annual progress update on the Effective Vaccine Management (EVM) improvement plan*
- *Updated CCE inventory (if receiving CCEOP support)*
- *HPV specific reporting (only if applicable)*
- *HSS end of grant evaluation (only if applicable)*
- *Post Introduction Evaluation (PIE) reports (only if applicable)*
- *Gavi transition and/or polio transition plans or asset mapping information (if applicable)*
- *Expanded Programme on Immunization (EPI) review / plan of action implementation report (if available)*

Note: Failure to submit the renewal requests as well as required reporting on the country portal four weeks ahead of the Joint Appraisal meeting (except for the vaccine renewal request, which is to be submitted by 15 May) may impact the decision by Gavi to renew its support, including a possible postponement, and/or decision not to renew or disburse support.

Country	Kenya
Full JA or JA update	<input checked="" type="checkbox"/> full JA <input type="checkbox"/> JA update
Date and location of Joint Appraisal meeting	10-14 December 2018; Nairobi Kenya
Participants / affiliation ¹	MOH, WHO, UNICEF, GAVI, CDC, CHAI, JSI, American Red Cross, KANCO, PATH, USAID, HENNET, Living Goods, Nextleaf Analytics
Reporting period	2018
Fiscal period ²	July 2017/June 2018
Comprehensive Multi Year Plan (cMYP) duration	July 2015 - June 2019
Gavi transition / co-financing group	<i>e.g. initial self-financing or preparatory transition...</i>

1. RENEWAL AND EXTENSION REQUESTS

Renewal requests were submitted on the country portal

Vaccine (NVS) renewal request (by 15 May)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
HSS renewal request	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
CCEOP renewal request	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>

Observations on vaccine request

Briefly comment on **assumptions and observations concerning the vaccine renewal/extension request and vaccine allocation**, such as quantification data triangulations conducted, target coverage used as basis for requested doses; available stock, stock-outs, variations/trends in the stock held & consumption; significant changes (+/-5%) in number of doses required, etc.

Population	49,116,617				
Birth cohort	1,635,583				
Vaccine	IPV	DTP-HepB-Hib	PCV-10	Rota	Yellow Fever
Population in the target age cohort	1,571,732	1,571,732	1,571,732	1,571,732	1,571,732
Target population to be vaccinated (first dose)	1,367,407	1,445,994	1,445,994	1,445,994	71,960
Target population to be vaccinated (last dose)		1,367,407	1,367,407	1,414,559	
Implied coverage rate	87%	87%	87%	90%	5%
Last available WUENIC coverage rate	78%	82%	71%	67%	1%
Last available admin coverage rate	78%	82%	82%	79%	1.6%
Wastage rate	20%	20%	10%	5%	50%
Buffer	3	3	3	3	3
Stock reported	393,100	3,798,200	3,861,200	2,045,330	0

Indicative interest to introduce new vaccines or request Health System Strengthening support from Gavi in the future³

¹ If taking too much space, the list of participants may also be provided as an annex.

² If the country reporting period deviates from the fiscal period, please provide a short explanation.

Indicative interest to introduce new vaccines or request HSS support from Gavi	Programme	Expected application year	Expected introduction year
	Typhoid Vaccine	TBD	TBD

2. RECENT CHANGES IN COUNTRY CONTEXT AND POTENTIAL RISKS FOR NEXT YEAR

*Comment on changes which occurred since the previous Joint Appraisal, if any, to **key contextual factors** that directly affect the performance of the immunisation programme and Gavi grants (such as natural disaster, political instability, conflict, displaced populations, inaccessible regions, etc., or macroeconomic trends, health worker industrial actions, disease outbreaks or severe and unexpected Adverse Events Following Immunisation, etc.).*

*For **fragile countries or countries facing humanitarian emergencies or hosting refugees**⁴: Please indicate if any flexibilities in grant management are being requested, and also mention in case the vaccine or HSS renewal requests were adjusted.*

*For countries transitioning from the **Global Polio Eradication Initiative**: Please briefly describe the impact on immunisation and primary health care services and specify whether the country has a polio transition plan in place. If such a transition plan exists, please briefly describe it. If no transition plan exists, please describe actions being taken to prepare for polio transition. Please also comment on whether Gavi investments are being used/expected to be used in the polio transition.*

Government

In the recent years, Kenya has made significant political, structural and economic reforms that have largely driven sustained economic growth, social development and political gains leading to robust growth..Kenya held its general elections in August 2017 and repeat Presidential elections in October 2017. Following the general elections, the national level witnessed changes in its top leadership. At the County, new government officials at the devolved level came into office with subsequent reorganization of existing health staff. The new County and sub-county officials had limited knowledge on health and immunization programming and planning. In the same year, the country experienced industrial actions by nurses which lasted for more than 6 months The nurses strike affected delivery of health services in general and more so immunization services which is mainly carried out by nurses resulting to increase in the number of children not accessing vaccines. Consequently, the immunization coverages of the various vaccines declined.

Economy

According to World Bank Statistics⁵, the Gross National Income per capita (Atlas Method) increased from \$1150 (2013) to \$1440 (2017). The GNI per capita was \$1310 in 2015 and \$1380 in 2016.

With economic growth averaging 5.8% since 2016, Kenya is one of the fastest growing economies in Sub-Saharan Africa. The economic expansion has been boosted by a stable macroeconomic environment. Medium-term GDP growth forecast 5.8% in 2018 and 6.1% in 2019 dependent on completion of ongoing infrastructural projects. The government has sought to optimize the growth for resilient social economic development with the launching of the “Big Four Initiative” that prioritizes manufacturing, universal healthcare, affordable housing and food security.

Health Sector Financing

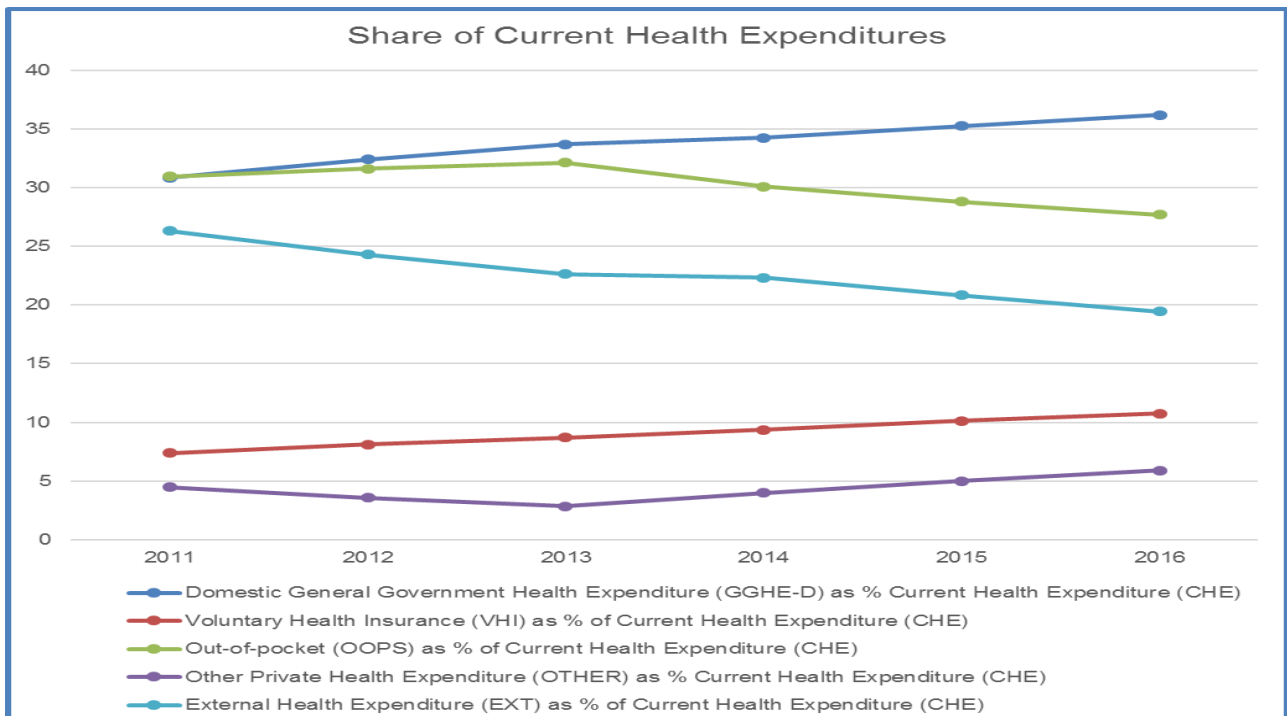
The health sector in Kenya relies on several sources of funding: domestic public resources (government), domestic private (firms, national faith based organizations and NGOs, households), health insurance schemes and external resources (external donors, public and private).

The current health expenditure (CHE) increased from \$57 (2011) to \$66 (2016), with increasing domestic resources and decreasing external resources. In terms of share, Government and health insurance show a slow upward trend while out-of-pocket a slow decrease and external health expenditure is definitely decreasing. There are signs of a progressive government commitment to move away from donor dependency¹.

³ Providing this information does not constitute any obligation for either the country or Gavi, it merely serves for information purposes.

⁴ For further information refer to <http://www.gavi.org/about/programme-policies/fragility-emergencies-and-refugees-policy/>

⁵ <https://data.worldbank.org/indicator>



The Domestic General Government Health Expenditure (GGHE-D) as % Gross Domestic Product (GDP), consistently below 2%, signals possible fiscal space for increased funding of health sector and by extension of immunization programme.

Universal Health Coverage & Presidential Declaration on Immunization:

The Ministry of Health and the County Governments have made significant investments and reforms that are aimed at transforming healthcare delivery in Kenya. The Country has prioritized Universal Health Coverage (UHC) in its Big4 agenda over the next 5 years. Immunization is basic right as articulated in the Constitution of Kenya and in the Children’s Act. As Kenya gears to attain UHC, immunization is a key pillar, critical to achieving UHC. UHC offers an opportunity to increase profile, funding and political support for the immunization program.

In order to address the large number of under/unvaccinated children, The President issued two Presidential Directives in June 2018 in support of Routine Immunization:

1. That the Ministry of Health, working in collaboration with the Ministry of Education and County Governments, institute measures to ensure that all children are vaccinated prior to joining elementary schools
2. That the Ministry of Health, working in close collaboration with County Governments, implement 100 day rapid results initiative (RRI), to vaccinate all children who may have missed out on immunization in a consistent and sustainable manner to ensure we attain our targets of universal immunization.

The 100 days RRI was implemented successfully and efforts are ongoing to institute measures in collaboration with Ministry of Education to ensure that all children are vaccinated prior to joining elementary schools. Further, the Cabinet Secretary (CS) for Health, took up the role of National Immunization Champion, advocating for immunization at high levels. The CS rallied and continues to champion for collective action within key Government institutions and county Governments in accountability for immunization performance at all levels.

Disease outbreaks

In 2018, the country experienced outbreaks of measles in 7 Counties (Garissa, Wajir, Mandera, Kitui, Tana River, Muranga and Nairobi), cholera and polio which constrained implementation of routine immunization system and stretched financial and human resources available. A total of 824 suspected measles cases were reported in 2018 with 73 confirmed cases and 3 deaths (CFR 0.4%). The confirmation of circulating vaccine derived polio virus from environmental sample in Kamukunji, Nairobi was a setback to the country’s

progress in polio eradication. Cholera outbreaks have persisted in several counties such as Tana River and Nairobi.

Adverse environmental conditions like droughts in the arid and semi-arid areas (Marsabit, Mandera, Garissa etc) and floods in Counties such as Tana River, Kilifi that occurred in 2018 adversely affected access to health and immunization services.

Gavi transition and Donor landscape (general funding for health sector and in specific , immunization, MTTP to see gaps in trends to justify need for resources)

The Country has over the last 15 years introduced six new vaccines with support from Gavi, using the co-financing model in which the country co-procures a portion of the six ‘new vaccines’ and safe injection devices requirements, by paying approximately 10% of the annual cost.

Since Kenya, is a lower middle-income economy, the objective is to put the country on a trajectory towards self-sustainability in order to prepare for phasing out of Gavi support for new vaccines. The timeframe for transition is determined by a Country’s GNI Per Capita (rolling last three year average), reviewed in July every year. Currently, the country is in the preparatory phase and in 2023, the country is projected to enter the accelerated transition phase, in which the Government is expected to rapidly increase the co-financing payments to self-sustainability over a period of five years in line with Gavi policy.

The country has sufficient resources locally to finance vaccines and an effective procurement and supply mechanism is in place to ensure uninterrupted availability of vaccines. In addition, there are efficient immunization systems (administrative and operational) in place to sustain vaccination of children.

The Immunization resource requirement is predictable in medium term, however to achieve long term sustainable immunization financing, in the face of Gavi transition, the Government needs to place strategies to assure this

Regarding polio eradication, the country has been heavily dependent on global polio eradication initiative. The country suffered a setback in 2018 with the confirmation of cVDPV2 from sewage sample in Kamukunji, Nairobi. As the global polio ramp down sets in, the country has mapped the polio resources, assets and skills. The country plans to develop a polio transition plan.

Kenya has put in place steps to assure safety and quality of vaccines. A surveillance for adverse events following immunization (AEFI) is in place and counties report any AEFIs. A vaccine safety strategy has been drafted which will guide actions towards assurance of safety of vaccines. As part of efforts to strengthen AEFI surveillance, the Kenya National Vaccine safety committee (KNVSAC) was established in 2018 to review causality of AEFIs and to build public confidence and reduce negative publicity.

Also provide a forward-looking perspective on what additionally may happen over the next year given current conditions, vulnerabilities, dependencies, trends and planned changes. This refers to potential events which, if they actually happened, would affect the ability to sustain gains or make further progress in the different areas described in this report. E.g. current uncertainties in demand may increase the risk of vaccine expiry next year, a current decline in coverage may increase the risk of outbreaks, or a currently planned election may require to anticipate potential social unrest and security challenges.

Drawing on existing country risk assessments, take the following aspects into account in identifying risks:

- *Upcoming changes in the immunisation programme (e.g. new initiatives and innovations) and the country context (whether political, economic, social, technological, legal or environmental) leading to new risks*
- *The possibility of new barriers to achieving critical objectives and milestones. Ask ‘what-if’ questions to focus on the exception, not on the norm.*
- *Dependencies on financial, human and material resources and third parties and whether these would continue to be available. Reliance on estimates or assumptions that may become no longer valid.*
- *Problems that have happened in the past or to others and the possibility that similar events (re)occur*

Please list a maximum of five most important risks (i.e. with a high likelihood to happen and / or a high potential impact if it did happen). Consider the need for proactive actions to prevent them from happening or to timely detect and effectively respond once they will happen. Also clarify whether these risk mitigation actions are being prioritised in the action plan (section 6 below).

Looking forward to the subsequent year, the immunization programme is expected to stabilize with improvement in coverages and reduced inequities. The health system is also expected to stabilize since the new health managers at national and county levels will have settled in their current positions. With the increase in coverage and the planned nationwide measles follow up vaccination campaign the number of measles/rubella outbreaks is expected to decline significantly. The availability of Gavi HSS grant is expected to bridge some of the gaps in the programme. Despite the positive outlook, the country faces potential risks. These risks include the following:

- Health workers strikes. Withdrawal of services of health workers at national or sub-national scope will affect delivery of vaccination services. The national MOH is and will continue to engage with counties and health professional bodies to address any grievances as they arise
- Disruptions in implementation of activities under the Gavi HSS grant due to delays arising from procedural bottlenecks. To mitigate this, the immunization programme and the coordinating unit will be proactive to ensure that the activities are implemented in a timely manner.
- Mismatch in distribution of vaccines and related supplies. In order to prevent this from happening, deliberate efforts will be made to ensure that bundling of vaccines and injection devices is done.

3. PERFORMANCE OF THE IMMUNISATION PROGRAMME

*This section is expected to capture primarily the **changes since the last Joint Appraisal** took place. It should provide a succinct analysis of the performance of the immunisation programme with a focus on the evolution / trends observed over the past two to three years and including an analysis of immunisation coverage and equity, as well as a review of key drivers of poor coverage. It*

Information in this section will substantially draw from the recommended analysis of coverage and equity and other relevant programme/service delivery aspects which can be found in the Joint Appraisal Analysis Guidance (<http://www.gavi.org/support/process/apply/report-renew/>). In addition, the annual desk review exercise is considered an important source of analytics that can be used for populating the Joint Appraisal report.

Countries are encouraged to present the information in tables, graphs and maps, and to reference the source of data.

3.1. Coverage and equity of immunisation

*Please provide an analysis of the situation related to coverage and equity of immunisation in the country, **focusing on new data & analysis, trends and changes, including outbreaks observed since the last Joint Appraisal** was conducted.*

*Provide a summary of the trends in **coverage and equity**, across geographical areas, economic status, populations and communities, including **urban slums, remote rural settings and conflict settings** (consider population groups under-served by health systems, such as slum dwellers, nomads, ethnic or religious minorities, refugees, internally displaced populations or other mobile and migrant groups). Relevant information includes: overview of districts/communities which have the lowest coverage rates, the highest number of under-vaccinated children, disease burden: number and incidence of vaccine preventable diseases (VPD) cases as reported in surveillance systems in regions/ districts, etc.*

Countries are strongly encouraged to include heat maps or similar to show immunisation coverage trends over time. Examples of such analysis are available in the Joint Appraisal Analysis Guidance (available via <http://www.gavi.org/support/process/apply/report-renew/>)

National Coverage

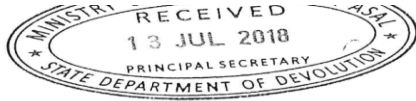
Immunization is a basic right as defined by the Constitution of Kenya and in the Children's Act. All immunizing health facilities (Public, Private, NGO and Faith based), receive vaccines procured by the Government of Kenya at no cost and expected to provide this service to children free of charge. In addition, they are mandated by law to report on their complete immunization performance on time on a monthly basis to improve the health and survival of our children.

The immunization coverage has remained stable over the years at 80%. In 2016, the national coverage stood at 81%, slightly below the national target of 90%. At least 40% of counties had coverage of 80% and above. The immunization coverage in 3 counties (Kiambu, Isiolo, Turkana) was above 100% probably due to influx of population from other countries/ counties. Majority (57%) of counties had immunization coverage between the 50-79%. The counties with lowest Immunization coverage were Mandera (37%), Wajir (55%), Nandi (61%). The low performance in Mandera is attributable to target setting challenges, presence of predominantly nomadic population, insecurity from neighboring war torn Somalia and inter-clan conflicts.

In 2017, a five-month and a three-month strike by government recruited nurses and doctors respectively resulted in significant disruption of health care services, including immunization. The immunization coverage dropped to below 70%. Mothers and caregivers had to turn to profit and non-profit private providers for immunization during this period. To mitigate against the effects of the strike however, the Ministry of Health with the support of the Kenya Red cross, UNICEF and other partners mounted a catch up campaign through which an 301,000 of an estimated 500,000 children that were missed were vaccinated.

Compared to 2017, the immunization coverage for 2018 has shown remarkable improvement across all the antigens. Although there has been significant recovery since the strike, the national target of 90% coverage for all antigens has not been achieved, at the time of this report preparation.

Significant Efforts were made despite simultaneously having to rapidly respond to a cVDPV outbreak which included conducting 5 SIA campaigns, and a measles outbreak in North Eastern Kenya. The President of Kenya demonstrated the highest level of political commitment to Immunization by directing the Ministry of Health and all Counties to ensure all children that previously missed vaccines are vaccinated and personally launched a Rapid Results Initiative (RRI) for the same in which he administered OPV to several children on national news channels.



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**THE PRESIDENCY
EXECUTIVE OFFICE OF THE PRESIDENT
HEAD OF THE PUBLIC SERVICE**

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When replying please quote

STATE HOUSE
P.O. Box 40530-00100
Nairobi, Kenya
4th July 2018

Ref. No. **OP/CAB 26/1/3A**
and date

Eng. Peter Kimplagat Tum, OGW
Principal Secretary
Ministry of Health
NAIROBI



Mr. Nelson Marwa, EBS ✓
Principal Secretary/Devolution
Ministry of Devolutions and the ASALS
NAIROBI

Dear *Mr Marwa,*

PRESIDENTIAL DIRECTIVE:

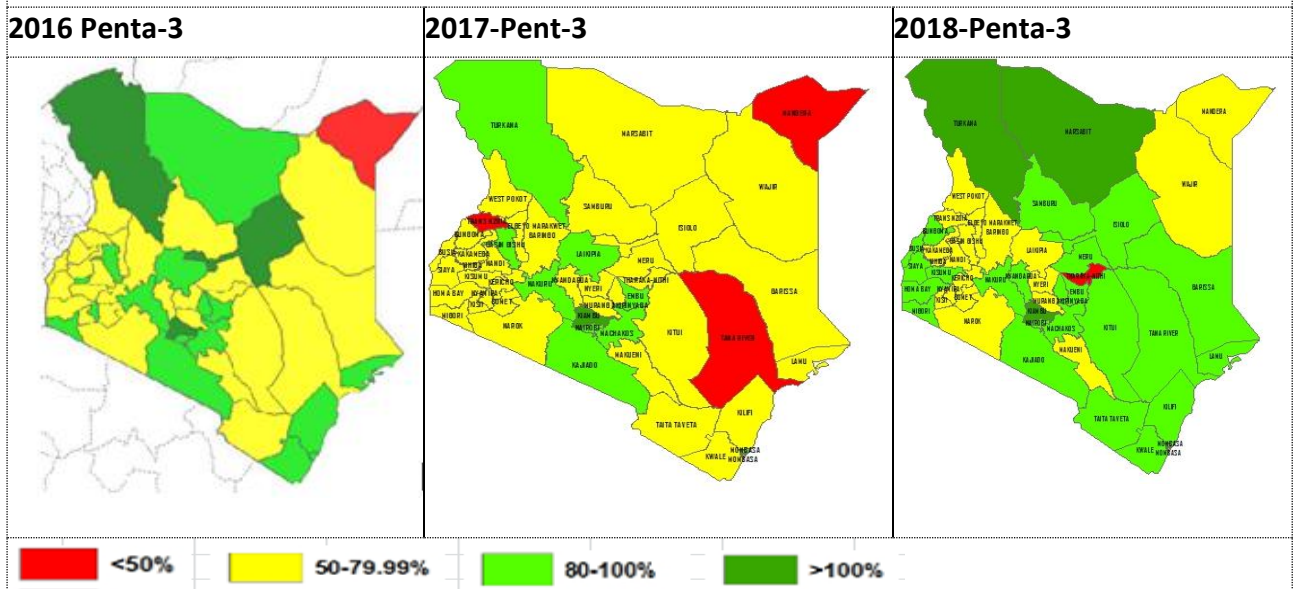
IMPLEMENTATION OF RAPID RESULTS INITIATIVE ON VACCINATION

While addressing members of the public during the official launch of the Accelerated Outreach for Immunization and the Send-Off of Cuban medical specialists to counties at the Kenya Medical Supplies Depot, Nairobi County on 27th June 2018, His Excellency the President directed the Ministry of Health working in collaboration with County Governments to start a 100 day Accelerated Rapid Results Initiative (RRI) to immunize all children who may have missed out during previous vaccination exercise.

Further, His Excellency the President directed that the campaign should be sustainable and consistently implemented to ensure it attains its target of universal immunization.

In 2018 (January to October), the national coverage of third dose of pentavalent (Penta 3) for immunization improved to 82%. All the counties achieved a coverage more than 50% for the period January- October 2018 for penta 3 and MR-1 apart from Tharaka-Nithi which achieved a coverage of 38% due to use of wrong denominator which is being addressed. Efforts are ongoing to improve further and sustain this performance, while bridging the gap in population immunity occasioned by the strike through accelerated outreach services at community level, ensuring uninterrupted supply of vaccines and provision of specialised vaccine storage equipment for every health facility in the country to improve access and contribute to UHC.

Penta-3 Coverage in 2017 and 2018



3.2. Key drivers of sustainable coverage and equity

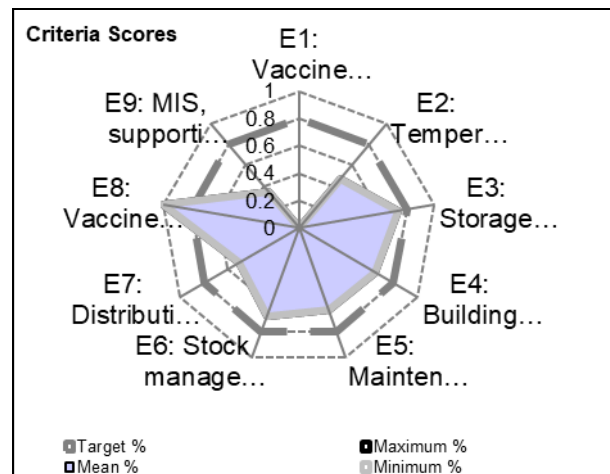
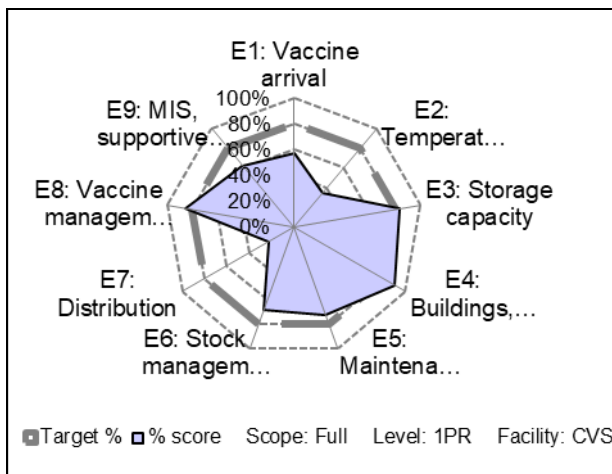
Please highlight the key health system and programmatic drivers of the levels of coverage and equity highlighted in the section above, **focusing on the evolution and changes since the last Joint Appraisal**. For those districts/communities identified as lower performing, explain the evolution of key barriers to improving coverage.⁶ To the extent possible, **please list the barriers below by order of priorities with regards to coverage and equity bottlenecks**

- **Supply chain:** integration, key insights from latest EVMs and implementation of the EVM improvement plan, and progress on the five supply chain strategy fundamentals.⁷

The National Vaccines and Immunization program is planning for a follow up EVMA since the last one done in 2013. However, there has been significant investments and improvements, with most of the recommendations having been implemented. Specifically stock management practices, cold chain capacity and performance, temperature monitoring and vaccine management. Following gaps and recommendations cited in the 2015 Gavi program audit report, the NVIP planned for and implemented all of the recommendations as set out in the audit. Subsequently, the program focused on further improving these and sustaining the initiatives. The NVIP conducted an EVMA self-assessment at the Central and Regional Vaccines Stores in 2017 and April 2018 respectively. The objective was to further establish specific areas with gaps, following implementation of the Gavi audit recommendations and institute a targeted improvement plan that would be used to accelerate improvement of EVMA indicator scores to the acceptable minimum of 80%. The web charts below show the findings of both assessments.

CVS EVMA Self-Assessment, April 2017

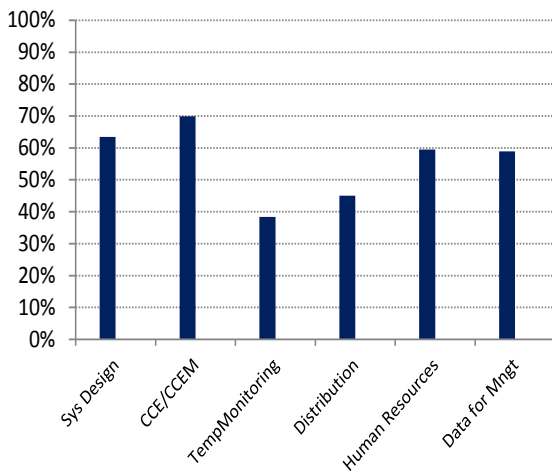
RVS EVMA Self-assessment April, 2018



RVS performance by 5 supply chain fundamentals

⁶ Relevant discussion questions on a number of the strategic areas here can be found in the programming guidance available on the Gavi website: <http://www.gavi.org/support/process/apply/additional-guidance/>

⁷ More information can be found here: <http://www.gavi.org/support/hss/immunisation-supply-chain/>



While the overall score did not meet the acceptable minimum of 80%, major gaps observed at both levels were related to temperature monitoring systems and vaccine distribution planning.

Since then a lot of effort has gone into further improving stock management practices including physical count procedures, temperature monitoring, cold chain maintenance and vaccine management practices.

The vaccine stores, however, continue to face staffing and financing for operations challenges. The NVIP plans to conduct a comprehensive EVMA at the end of quarter one in 2019 to assure continuous improvement. In addition, the progress made in the five supply chain strategy fundamentals is outlined below:

- *Supply chain leadership*

The program conducts annual joint planning and forecasting workshops with the participation of national and county EPI focal persons and other immunization stakeholders in charge of the vaccine supply chain. This exercise gives participants an opportunity to plan for and establish resource requirements. The program uses this opportunity to build managerial capacities through knowledge, skills and experience sharing.

In 2018, over 100 medical engineering technicians were trained to oversee and implement cold chain maintenance at county level. The NVIP has continued to explore opportunities for continuous professional development and trainings for its staff. An example is the recent capacity building initiatives undertaken during the implementation of the CCEOP, and deployment of Government procured equipment under a Loan from the World Bank. Further, two depot staff have so far attended a short course in Vaccines supply and logistics management, one officer is currently pursuing a Health commodities supply chain management Master’s program at the University of Rwanda’s school of public Health, EAC Regional Centre of Excellence. The aim is to ensure improved competencies and leadership in supply chain management.

The program is also working with Gavi to implement the Gavi STEP programme early 2019 that will target fifty senior vaccines supply chain management practitioners with Supply chain training and mentorship. It is envisioned that this will provide a pool of mentors with adequate skills who will in turn support and downstream immunization officers to improve vaccine management standards and practices.

- *Continuous improvement & planning*

The last EVMA was conducted in 2013 and Kenya is due for a follow up assessment scheduled for Q1 of 2019. Studies done in 2018 aimed at improving the immunization supply chain system include: a) the ELMA Study, “Using RTM to provide visibility into CCE performance for timely action”. b) Temperature Monitoring Study in Q2 of 2018 to assess and improve the CCE performance and practices for vaccines in storage (CVS to HF and outreach sessions) and during transportation. The introduction of IMPACT TEAMS in 11 Counties supported by JSI for targeted mentorship and teamwork has generated a culture of data utilization for

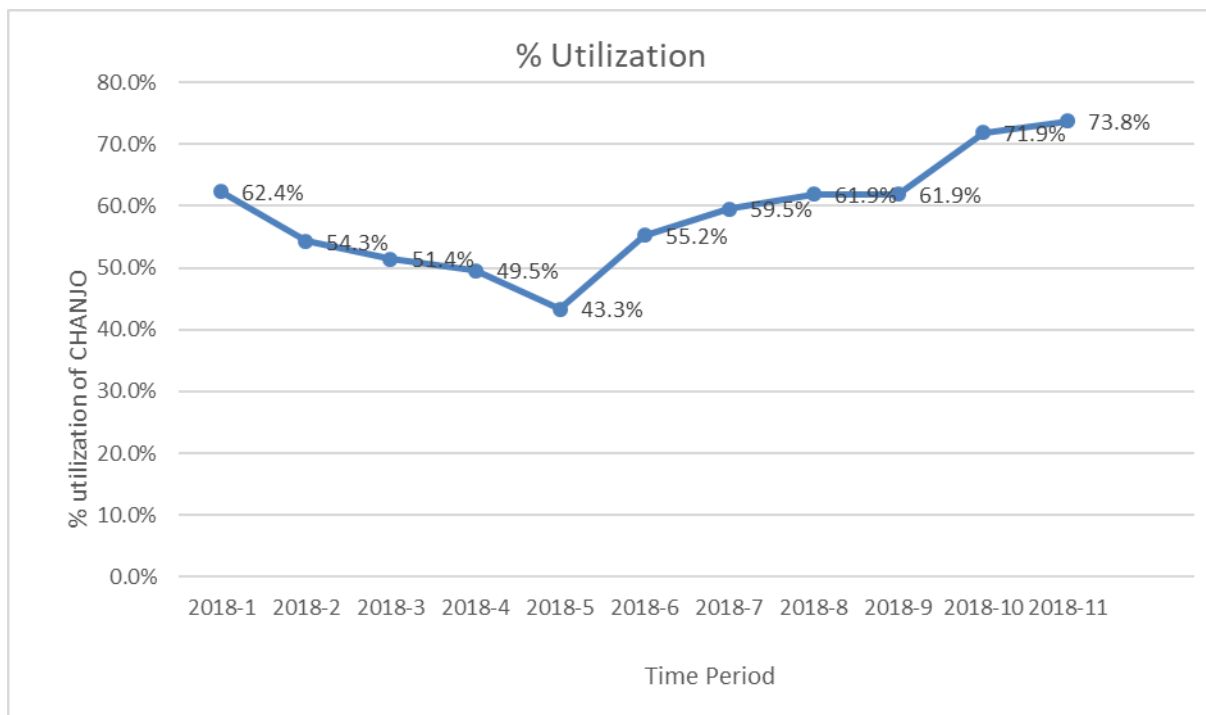
action in health workers in these areas. The findings of these assessments and studies guided strategies and activities included in the cMYP (2019-2023) draft and the draft 2019 EPI Annual Work Plan

- *Supply chain data for management*

The country has strong data management systems including vaccine stocks in place. However, the country has experienced interrupted supply of vaccines and injection devices to a variable extent at the service delivery points, resulting in about 20% of the health facilities being unable to offer vaccination services on a daily basis, as reported in the EPI review of 2018.

This is could be attributed to a number of factors like inadequate cash flows affecting shipment plans, weak and unreliable distribution mechanisms at lower level and inadequate stock management practices. Financial support to the vaccine supply chain system varies across counties. The NVIP Plans a more indepth analysis to better understand the reasons for stock outs at the service delivery levels and to recommend context specific actions. Further, as recommended in the EPI review report, the program plans to centralize procurement of injection devices and bundle with vaccines during distribution downstream, to eliminate any supply mismatch that impacts on service delivery. 16 counties categorized as low performers benefitted from Gavi HSS-funded vehicles that are expected to facilitate timely distribution of supplies and support supervision. The program continues to enhance use of existing stock data tools and explore strategies that will increase visibility and monitoring of stock situations regularly, especially at service delivery points. The country plans to work closely with UNICEF, CHAI, Jomo Kenyatta University and JSI in initiatives focussed on improving data visualization, institutionalize regular data review using key performance indicators to inform decisions at national, county and sub-county levels. The eLMIS (Chanjo®) system utilization 2018 trends at subcounty level are as shown in the graph below. Utilization is currently at 75%.

Table 2: Chanjo®) Utilization 2018



The Country plans to scale increase utilization to 100%, with the Technical support of the Jomo Kenyatta University School of Computing, a Government institution, set up a database/ Immunization repository, linking the stock management data to other data elements and key reports. Data triangulation will be

explored to ensure that stock data is viewed side by side with coverage, cold chain and others data to facilitate enhanced problem solving and monitoring of data quality and system performance. Further, to support this process, EVM Standard operating procedures have been developed and are set to be disseminated to all levels.

The planned improvements on the system promises to significantly improve real-time visibility of stock data at levels of implementation when used optimally. There will help improve data availability and use to promote continuous improvement in the supply chain.

The program has also embraced use of UNICEF-ViVa which give upstream supply visibility to inform shipment schedule

The program held a Logistics Thematic Group workshop to coordinate and draw synergies among all partners involved in ISCM initiative to ensure proper alignment to program priority objectives as well as explore feasible innovations out there.

Interventions targeted for supply chain optimization include:

- Use of Block chain technology in supply chain management
- Use RTM for cold chain data collection, analysis and use
- Creation of a data repository, with Linkages and Triangulation of immunization data
- Analytics on Chanjo

- *Cold chain equipment*

Capacity

The cold chain forms the backbone of any immunization program as vaccines have to be administered in their potent form to confer immunity. In August 2016, the program developed a 5-year Cold Chain Expansion and Rehabilitation Plan (CCERP 2017-2021) to guide investment in cold chain during this period. The gaps identified took into consideration the country's vaccines stockholding policy at different levels of the supply chain, population growth and planned vaccines introductions. Implementation of the CCERP started in 2018 where the Country procured cold chain equipment worth Ksh. 507.5 Million under the Gavi CCEOP. In order to supplement efforts towards accelerated immunization performance, the country further prioritized procurement of CCE worth Ksh 750 Million from a World Bank Loan. 3,282 refrigerators were procured in total. Of these, 621 went to HFs that initially did not have CCE, hence could not offer immunization. Expanding service coverage closer to the community is one way to reduce unreached children. In line with the CCERP, 1277 facilities that had PIS equipment received replacement with PQS grade A technology. Further, of the 1592 inventoried HFs who had PQS compliant equipment, 266 who had been projected to develop capacity gaps by 2021 received additional equipment. 101 Sub county stores with capacity gaps estimated at 16,100 litres received approximately 72,000 litres.

In addition, the country procured cold rooms to be installed in the Arid and Semi-Arid counties of Garissa, Mandera, Wajir and Turkana to expand their vaccine storage capacity and more than 3,300 vaccine carriers and cold boxes to facilitate outreaches. Installation is scheduled to happen in Q1 of 2019.

Infrastructural challenges affect all counties including dry storage space. This has affected installations in some counties especially at subcounty level where some lack appropriate buildings to accommodate cold chain stores.

CCE Maintenance

A number of spare parts were procured alongside the refrigerators. Through Gavi HSS support, 17 counties were able to carry out preventive maintenance of their equipment, with a similar allocation available in year 2. In addition, the program procured 48 motorbikes and toolkits to support maintenance activities in every county. Distribution of these items is ongoing. In 2018 a total of 100 medical engineering technicians were trained in cold chain installation, management and maintenance. The country is exploring strategies to better collect and utilize temperature data to guide maintenance activities more efficiently. This includes installing RTM devices at all subcounty stores, with support from Nexleaf and Gavi. Currently, a number of

CCE technologies deployed have inbuilt TM systems while others have stand-alone systems that generate a lot of data. There is need to standardize or draw points of similarities and establish how the data can respond to information needs of the program. A Temperature monitoring-specific workshop, which will bring together relevant partners and experts, is planned for Q1 2019.

To prepare for year 2 CCEOP deployment, NVIP plans to update its CCI inventory and review the CCERP to reflect current gaps

- *Supply chain system design*

The Vaccine supply chain is 4-tiered with one Central Vaccine Store, nine regional stores that serve 291 subcounty stores. Vaccine procurement is done at national level by NVIP. All EPI vaccines are procured through UNICEF. The Government of Kenya also has a financing agreement with UNICEF called the vaccine independent initiative (VII) which provides a mechanism to maintain an annual group procurement of vaccines while encouraging governments to finance and assume increasing responsibility for procurement of vaccines on the international market. It is a form of financing buffer that allows countries to pay after delivery of vaccines to them. This mechanism has been utilized to ensure steady availability and supply of vaccines.

Clearance of vaccines at port of entry is outsourced to a Third Party Logistics company who then delivers them to the CVS. Vaccines are then distributed to the 9 regional stores on a quarterly basis. This technically is a pull system as all level sent their requirements to higher level. The counties/ sub-counties then collect vaccines from regional stores on a quarterly basis and service delivery points collect monthly. With the devolved system of governance, County governments handle sub-national distribution. Practice varies with some counties consolidating their needs and collecting as one, while others have opted to form County stores. There is need to assess current design and advise on the most efficient design that can fit the country's context.

- ***Service delivery and demand generation: key insights related to service quality improvement and community engagement strategies, integration and cost-effectiveness strategies, demand for immunisation services, immunisation schedules, etc***

The National Immunization services in Kenya is managed by the Ministry of Health through the National Vaccines and Immunization Program (NVIP). NVIP provides policy direction, oversight and technical support to implementation for the routine immunization that occurs at the county level through a network of over 7,000 sites, fixed, mobile fixed and outreach sites; Public, Private, FBO and NGO. The program is classified as strategic national program.

The National vaccine and immunization programme provides vaccines free of charge in order to eliminate economic barriers to immunization, in the context of the national health sector strategic plan (NHSSP)

The recent EPI review conducted in the country highlighted some key service delivery issues that need strengthening. Most health facilities visited had inadequate staffing with only one health worker responsible for vaccination and delivering other health services; the one nurse becomes overwhelmed with many responsibilities. This has led to failure to immediately record the children as they are immunized, resulting in incorrect recording of the number of children immunized. In the 12 counties where the 2018 EPI review was conducted, 18% of the children who received vaccination services were not recorded in the tally sheet nor in the immunisation register. Further, not all planned outreaches were conducted as planned. Reasons for not conducting outreaches were due to limited financial resources in 29% of the health facilities visited???? and inadequate human and material resources in 23% of the health facilities. These factors contribute to increasing number of unvaccinated children in Kenya.

Inequity in access to immunization services among counties is a great contributor to performance gaps.

This may be due to immunization strategies that are not designed to reach the underserved populations, inadequately financed micro-plans, inadequate human resources (capacity, skill and distribution), commodities stock out at the health facility level, and inadequate capacity to provide vaccination services. Other reasons for not meeting coverage targets include the high dropout rate due to inadequate capacity to capture, analyze and use data; service delivery model that is not flexible to cater for underserved/special population groups, missed opportunities for vaccination, inadequate supportive supervision, weak defaulter tracing mechanisms and low awareness among the target population. In spite of counties being responsible for service delivery, limited funding allocation for immunization priorities has led to poor implementation of the full components of the RED approach. Due to poor accountability framework between national and County Governments, national policy guidance on immunization funding are not always followed and are difficult to enforce.

There are key underlying challenges that have been highlighted especially after devolution. In spite of clearly defined roles and responsibilities, some counties continue to experience low prioritization of immunization services, weak coordination of program, delayed or non-procurement of injection devices and documentation tools, weak or no supervision, and poor implementation of service delivery strategies. As new healthcare providers are being employed by the counties, they often lack prerequisite knowledge and skills to effectively offer immunization services. New EPI managers appointed by county governments also have inadequate leadership and management skills to effectively plan and provide oversight of immunization service delivery which is compromised by lack of support from the decision makers at the county level. However, there are opportunities that can be used to improve service delivery. The Counties are hiring more health staff to reduce the HR gap and improve service delivery. Nevertheless, this is still way below the required staffing norms to be able to perform effectively.

There has been tremendous progress in the GAVI HSS focus counties as they scale up RED/REC activities. The program conducted EPI Operational Level ToT and training of health care workers at service delivery levels in 9 GAVI HSS counties. The remaining 8 counties will be covered in 2019. In order to scale up RED/REC activities to the remaining 30 counties, the program will need extra budgetary support to finalize and disseminate the revised operational level training guides, adopt the REC strategy tools and to develop job aids for health workers.

KAP studies were conducted in low performing counties in 2017 and 2018. Key findings were inadequate knowledge among care-givers about vaccine preventable diseases and the need to complete immunization schedule. Healthcare workers were had communication skills as evidenced by their inability to effectively communicate to care givers on the same. Health workers did not always explain key messages: vaccine being given, benefits, when to return and side effects if any that would create confidence in vaccines and vaccination programme. There is there a need to develop communication guides for health workers and CHVs and continually train them on effective interpersonal communication.

Some parts of the country experience hesitancy to vaccination due religious concerns about safety of vaccines. This has an ongoing concern and strategies to address it are included in the crisis communication plan which is in its final stages of development.

There is need for continued Community mobilization and engagement in a systematic manner to ensure our coverage and equity objectives are met. Even though there are strategies to engage community, religious leaders and non-health stakeholders in immunization, this has been ad hoc and inadequate leading to insufficient community ownership. There is a need to strengthen this engagement and include health professionals, civil society and other stakeholders including political leaders, people practicing alternative medicine, professional bodies etc.

The program is leveraging on the HSS funding to update and implement communication plans at all levels as outlined by the National Immunization Communication Plan. Mass media and social media digital platforms such as Facebook, Twitter, WhatsApp will be used to share information on routine immunization and issues of public concern.

As supply chain barriers such as stock-outs has a negative impact on uptake of vaccines, the program will in addition focus on linking demand creation activities to service availability.

- **Gender-related barriers faced by caregivers⁸:** *Please comment on what barriers caregivers currently face in bringing children to get vaccinated and interventions planned or implemented (through Gavi or other funds) to facilitate access to immunisation services by women for their children. (For example: flexibility of immunisation services to accommodate women's working schedules, health education for women on the importance of vaccination and social mobilisation targeting fathers, increasing the number of female health workers etc.)*

According to a knowledge, attitude and practice rapid assessment conducted in four counties, more than 30% of the care givers interviewed across the different counties, were unaware/unsure of the routine immunizations schedule and how it should be administered to the children. The respondents could hardly match the vaccine name with the diseases it protects against and when it should be administered. There is need to increase caregivers knowledge on the national immunization schedule.

In Nairobi County, majority of the respondents (**67%**) felt that mothers are the main determinants on whether children are taken for immunization. 26% of fathers were involved in the decision to taking children for immunization. Therefore it is important to package information to appeal to fathers to participate in immunization programs.

To address this issues, the programme will implement activities on public health education on the vaccination schedule through health workers and the media - found as the most credible sources of immunization information.

- **Health Work Force:** *availability, skill set and distribution of health work force*
- **Leadership, management and coordination:** *leveraging the outcomes of the Programme Capacity Assessment and/or other assessment, please describe the key bottlenecks associated with management of the immunisation programme; this includes the performance of the national/ regional EPI teams/health teams managing immunisation (e.g. challenges related to structure, staffing and capabilities), use of data for analysis, management and supervision of immunisation services, and broader sectoral governance issues*

In the year 2018, the country had a National Comprehensive EPI review, which included sections on Program management and Leadership with the following findings:

- There are supportive legal frameworks and policy documents i.e. Constitutional provision that guide the functioning of the NVIP such as , Health Laws (Amendment) Act 2018, and Child Right Act; Kenya Health Sector Strategic Plan; Kenya Health Financing Strategy; cMYP; Kenya National Policy Guidelines on Immunization (2013)
- There is evidence of engagement with parliamentary health committee and County health committee as well as CSOs push for immunization to be part of discussions in the political space
- There is Political commitment as evidenced by the Government of Kenya (GoK) funding of traditional vaccines procurement and meeting their Gavi co-financing contributions to the new vaccines. Also, the programme has relied on the UNICEF Vaccine Independence Initiative (VII)

⁸ For additional programmatic guidance refer to <http://www.gavi.org/support/process/apply/additional-guidance/#gender>. Gender-related barriers are obstacles (for access and use of health services) that are related to social and cultural norms about men's and women's roles. Women often have limited access to health services and are unable to take their children to get vaccinated. Barriers include lack of education, lack of decision-making power, low socio-economic status, women unable to move freely outside their homes, inaccessibility of health facilities, negative interaction with health workers, lack of father's involvement in healthcare etc.

platform to ensure that vaccines are always available in the country. It is important to mention that the programme is able to compute the investment requirement for immunization as reflected in the cMYP

- The national programme procure and distribute vaccines and cold chain equipment to all health facilities: private, public, Faith Based organizations (FBOs) and Non-Governmental Organizations (NGOs) at most importantly at no cost to recipients
 - There is strong partner engagement with Immunization programme at National Level and in some counties with all partners involved in the planning implementation and evaluations/assessments. Partners involved include WHO, UNICEF, CHAI, JSI, Path, USAID and Civic organisations such as Hennet and KANGO
 - A major strength for the programme is quality of leadership at NVIP, and at many of the other government institutions. There are capable and knowledgeable people. However, there is need as in any situation with dynamic and changing environment to continuously strengthen the management skills of operators. This will reposition them to being strategic, rather than being reactive to be better proactive on issues affecting the programme but big problem
 - Health worker training has been focused on new vaccines and campaigns, not really on routine immunisation per se. has not been overall strategic view of training. However with the HSS a curriculum and a certification mechanism to certify and accredit training has been put in place. The Target is to train at least half of health workers under this new curricula within the first 18 months. The training duration is as follows:
 - a. 1 week for basic
 - b. 2 weeks for advanced and
 - c. 3 weeks for Mid-Level Managers (MLM).
 - The 2017 industrial action (strike), lasting more than six months by nurses affected service delivery significantly. Consequently, there were significant gaps in service delivery, vaccine management and recording and reporting during this period. In order to ameliorate the situation, some nurses were recruited through The Red Cross on an adhoc basis to give immunizations. The upsurge in workload as a result of backlog of people requiring vaccination led to errors in recording and reporting as observed in the data.
 - In most health facilities visited there was inadequate staffing with only one health worker responsible for vaccination and delivering other health services, the one nurse becomes overwhelmed with many responsibilities. This led to failure to record the children as they were immunized immediately hence, end up recording incorrectly the number of children immunized. This was further evidenced during observation at the immunisation session where 18% of the Immunisations were neither recorded in the tally sheet nor in the immunisation register
- **Other critical aspects:** any other aspect identified, for example based on the cMYP, EPI review, PIE, EVM or other country plans, or key findings from available independent evaluations reports⁹.

- Carry out a more in-depth review of reasons for stock outs at service delivery level and come up with strategies to address the problem
- Procure and distribute all vaccines bundled with injection safety materials to ensure uninterrupted services at delivery level
- Periodically review CCE rehabilitation and expansion plan to include all new health facilities requiring CCE
- Address training gaps on surveillance and AEFI at all level

⁹ If applicable, such as Full Country Evaluations (relevant for Bangladesh, Mozambique, Uganda and Zambia) and Technical Assistance evaluations (conducted for Gavi Partners' Engagement Framework tier 1 and tier 2 priority countries).



3.3. Data

Provide a succinct review of key issues related to the timely availability, quality and use of immunisation data **focusing on the evolution and changes since the last Joint Appraisal**. This section should at least cover insights on immunisation coverage data (target populations, number of children vaccinated) and available triangulation with vaccine supply chain data, vaccine preventable disease (VPD) surveillance data, and adverse events following immunisation (AEFI) data. Please take the following aspects into account:

- Status of the **health and immunisation information system** (e.g. DHIS2, parallel systems, surveillance system), and updates on eventual national HMIS strengthening plan.
- **Denominator**-related information, e.g. any difference between national denominator, UN estimates, and programmatic targets, and planned census,
- Key challenges pertaining to **data availability, quality and use**, referring to results from most recent annual desk review, any recent assessments and implementation of immunisation data improvement plan. For example, are you aware of key limitations / weaknesses related to the quality of the data and data analyses you have used to inform this Joint Appraisal.
- **Compliance** with Gavi's data quality and survey requirements (the requirements are listed in the JA Annex; and are described in detail here <http://www.gavi.org/support/process/apply/additional-guidance/#data>). If you are not compliant, explain why.
- **Main efforts / innovations / good practices** focused on evidence-based data improvement interventions and level of scale up.

Status of Health and Immunization Information Systems

Kenya through the Ministry of Health has adopted DHIS 2, a web based platform tool where immunization data is reported among other health sector indices. The DHIS2 is managed through Health Information Systems Unit within the Ministry of Health. The Routine immunization data collected at the health facilities and transmitted by 5th of the following month to the sub-county using standardized immunization summary tools (MOH 710). At the sub counties, the data manager collates data from all health facilities and uploads them onto the DHIS2, by the 15th of the following month. The completeness of reporting rate as of October 2018 is 95% The DHIS2 consist of data elements on routine immunization including administration and vaccine stock data at the health facility level. Over the past 3 years, the program is implementing a logistics management information system in the counties and sub counties to increase vaccine stock and cold chain data visibility. However, findings from the EPI review revealed that only 66 percent of the sub counties were using the system.

While the country has a robust data management system in place, there have been disparities between administratively reported coverage and those obtained through household surveys including the latest DHS in 2014.

The national immunization program is currently implementing several measures and strategies to improve coverage and data quality at all levels. A Data Quality Improvement Plan (DQIP) has been developed and implementation is expected to ameliorate systemic challenges to data quality. Further, the ministry intends to implement strategies to improve data visibility to facilitate faster decision making. To improve data quality the program with the support of CDC piloted Electronic Vaccine Register in 10 health facilities in Siaya County. However, little progress has been made in pilot implementation. Lessons learn for this pilot would be used to scale up to the whole county.

The country also utilizes surveys and studies including Kenya Demographic Health Surveys (KDHS) to generate additional information to inform decision-making. The last DHS was conducted in 2014 and Key Indicators Report is available. A post measles-rubella SIAs coverage survey was also conducted in 2016, covering aspects of routine immunization performance also. The findings were in agreement with those of previous DHS.

Denominator related information

The National and Programmatic denominators are the same, and are drawn from Population projections by the National Bureau of Statistics. Denominator challenge in many counties exist, especially those with informal settlements and large number of undocumented migrants with resultant persistently low coverage, due to overestimation of population size. These then constrain the computing of actual

coverage figures.

The country is due for a national census in 2019, which it is hoped will help resolve the denominator issues.

Challenges to data availability, quality and use

County governments are responsible for service delivery and reporting, printing of county documentation and reporting tools, receiving and analysing of routine immunization and surveillance data. They are able to access DHIS2 and liaise with their respective sub counties on irregularities of data in the system, and convening quarterly performance review meetings in the counties among other responsibilities.

However, review meetings with utilization of data for decision making are not regularly done at the national, county and facility levels.

At the sub county level, the data managers receive reports from all the health facilities using a checklist every month. Their mandate is to verify reports for consistency, completeness before entry into the DHIS2 and liaise with the health facilities on data irregularities. However, at the sub counties, the capacity of using computer technology to analyze, interpret and use data is minimal; and there is inconsistent data entry due to lack of airtime/poor network in some counties affecting reporting and timeliness.

The program has instituted a quarterly bulletin to provide standard feedback to peripheral level on status of stock adequacy, cold chain maintenance, immunization coverage completeness and timeliness of reporting

The health workers at the community and facility levels are mandated to record daily vaccination events of eligible population in the relevant data capturing tools, maintain a daily record of the vaccines and diluents used, verification of completeness of data capture tools on a daily basis, fill and submit AEFI reports as they occur and submit summary reports to the sub county on 5th of every month.

In 2018 the program conducted joint immunization performance review, target setting and denominator harmonization forecasting workshop with the 47 counties. This provided an opportunity for sharing best practices amongst the counties and advocating for immunization as a key priority agenda in county discussions.

Despite the above efforts, poor data quality still remains a key challenge to the immunization program with only 62% (n=45) of HF reporting accurate data (EPI Review,2018). The key drivers to poor data quality are: -

- (i) Errors at the health facility level in counting, aggregating and transferring data. These are largely as a result of Human resource capacity challenges at the health facilities in numbers and in data capture, analysis and use and may prioritize service delivery over rigorous data capture from multiple programs. The country seeks to leverage on the various training opportunities including new vaccine introduction, operational level trainings, Micro-planning and data quality improvement plan to improve data management.
- (ii) Challenges related to printing and dissemination of reporting tools, leading to lack of updated tools at the health facility levels. The program keeps an updated version of immunization tools that are shared with the counties for printing and dissemination. Plans are underway for the program to engage with the counties to ensure streamlining of the printing of documentation tools
- (iii) Missing values and or information on primary source documents, with increased cases of under-reporting and over reporting of program indicators in health facilities with only 62% of the Health Facilities providing accurate data.

The program plans to perform frequent DQSA, desk reviews, training on data management processes, roll out Data Management SOP's and implement an automated monthly performance bulletin using data from DHIS. The EPI policy, Manual and guidelines will be updated and disseminated.

Partial triangulation of data was performed between stock adequacy and coverage (A report is available) .The program to systematically plans to institute a culture of regularly reviewing data and monitoring KPIs and using this information for decision-making at the national and sub-national levels.

Inadequate support supervision by the counties, irregular quarterly review meetings, non-implementation of data quality self-assessment. In the next 3 years, counties will be supported through the HSS to conduct supportive supervision as well as data quality self-assessment even as they establish their local mechanisms of addressing these issues.

In addition, data handling, analysis and consumption is not optimal, due to inadequate analytical skills of health managers. There is need to build capacity of health workers to utilize the data they generate. An annual data quality assessment is planned to be conducted through the HSS and this will include health worker training at sub county level. The program plans to pilot and scale meaningful data review meetings through supporting skills transfer through periodic review of programmatic, data analysis and presentations at the sub-county level.

Surveillance Data

The surveillance structure and network exists from the national level to the community level. In 2016, Kenya conducted an External Surveillance Review. It was noted that the current performance of the surveillance system in Kenya is not robust enough to allow timely detection of transmission of VPDs.

The review noted crucial gaps in financing of surveillance activities. Consequently, one third of the country's Sub-Counties had below standard AFP surveillance indicators. There was a knowledge gap in vaccine preventable disease surveillance; particularly at the tertiary HF levels. High staff turnover, lack of feedback from the laboratory to the Health Facilities and long turn around times also pose challenges to surveillance and compromising the quality of data collected.

The review recommended strengthening of the sensitivity of the surveillance system by:

- I. Capacity building of key staff, including private sector;
- II. Conducting and documenting active surveillance;
- III. Enhancing supportive supervision and providing feedback.

In 2017, Integrated supportive supervision reporting on ODK platform was introduced in the country. Reports received are analysed and feedback shared. Subnational level, WHO and partners are using and reporting in the tool. The country is looking to implement a systematic way of reviewing the feedback and taking corrective action.

Main Efforts, Best Practices

1. The reporting of immunization coverage through the DHIS2 and performance monitoring on quarterly and monthly reviews respectively at county and sub-county levels stood out is a major strength and achievement of the program. The coverage monitoring system is well established using DHIS2 as part of HMIS
2. The implementation of the data quality improvement plan (DQIP) developed in 2016 is in progress
3. Data collection and data monitoring tools as well as defaulter tracking tools exist in, most the facilities visited. The program is working on standardizing the formats
4. Good data management practices especially the data archiving where almost all HF (96%) had copies of the filled in summary sheet (MOH710) of which the 95%(n=43) were completely filled in, whilst 79% data was consistent
5. Quarterly integrated program review meetings are held at county level, where sub-optimal performing sub-counties and HF are identified and provided with additional support by county teams. Most counties, and 86% of sub counties report holding these monthly review meetings
6. Seventy two percent of sub-counties hold data review and harmonization sessions while 77.8% (n=45) of Health Facilities have correctly updated monitoring charts
7. Design, development and use of immunization score cards as a tool to present immunization data

3.4. Immunisation financing

Please provide a brief overview of the main issues affecting the planning, budgeting, allocation, disbursement and execution of funds for immunisation. Please take the following aspects into account:

- **Availability of national health financing framework and medium-term and annual immunisation operational plans and budgets**, whether they are integrated into the wider national health plan/budget, and their relationship and consistency with microplanning processes.
- **Allocation of sufficient resources in national health budgets for the immunisation programme/services**, including for Gavi and non-Gavi vaccines, (integrated) operational and service delivery costs. Discuss the extent to which the national health strategy incorporates these costs and any steps being taken to increase domestic resources for immunisation. If any co-financing defaults occurred in the last three years, describe any mitigation measures that have been implemented to avoid future defaults.
- **Timely disbursement and execution of resources**: the extent to which funds for immunisation-related activities (including vaccines and non-vaccine costs) are made available and executed in a timely fashion at all levels (e.g., national, province, district).
- **Adequate reporting on immunisation financing and timely availability of reliable financing information to improve decision making**.

a) **Availability of national health financing framework and medium-term and annual immunisation operational plans and budgets, whether they are integrated into the wider national health plan/budget, and their relationship and consistency with microplanning processes.**

There is an existing Health Financing Framework, with dedicated financing for immunization. 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). In addition, almost all of the Human Resource costs, Distribution costs and Utility costs that form the bulk of immunization expenditure are financed by the Government.

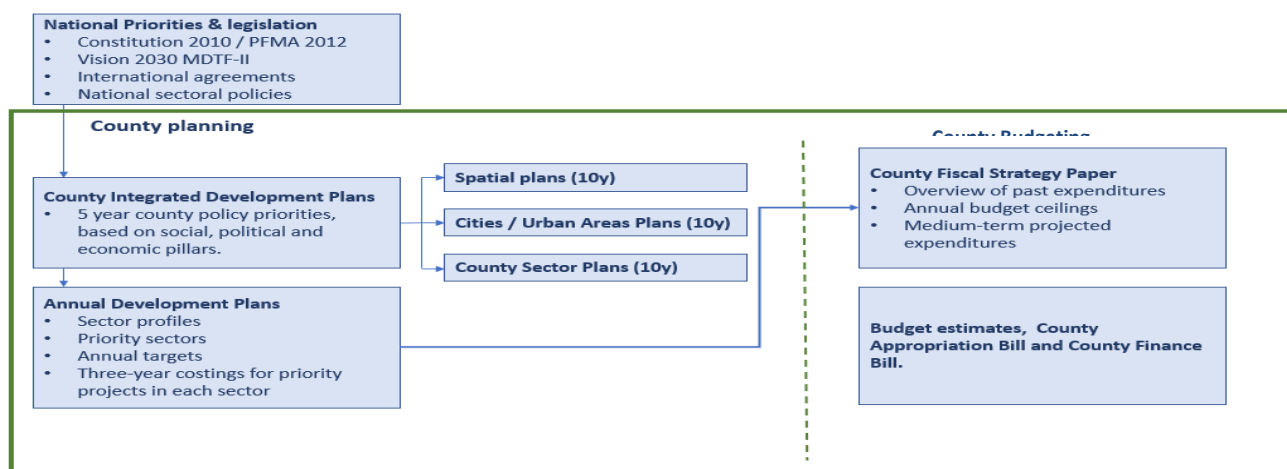
The budget process for Kenya is set out in the Public Financial Management Act 2013 (PFMA, revised 2015). Kenya applies a medium-term planning framework. At the national level this is called the Budget Policy Statement (BPS) and at the county level it is known as County Fiscal Strategy Paper (CFSP).

The budget formulation process is managed by the Cabinet Secretary (Treasury) and begins with the publication of the Budget Circular in August of every year, where the macro-economic expectations, priorities and processes related to program based budgeting and prioritization of resources are described.

- At the National level, each year the National Treasury must table the BPS in Parliament. In the BPS, several important decisions are made, including: The overall size of the national budget (revenue, spending, and deficit); the sector distribution of the budget (share of the budget for health, education, etc.); how revenue is divided between the national and county levels. Following this, Treasury requests the Ministries, Departments and Agencies (MDAs), i.e. MoH and counties, to develop and submit the detailed budget for their respective areas. Based on the overall allocation to the MoH, an internal process exists where MoH collects budget requests from the spending units within MoH, including immunization, where the estimates from the costed cMYP should fit. The process takes place in the first quarter of the calendar year
- At county level, Budget processing in relation to immunization is developed within the boundaries of the national law and with little direct influence from the National Treasury. Counties receive their share of the revenue via the resource allocation formula and conditional grants. There are few limits on spending, other than the PFM act which states they must be in line with medium term priorities, use conditional grants for their intended purposes and spend no more than 70% on recurrent expenditures.

The budgeting processes follow a Program Based Budgeting (PBB) approach. In addition, At the county health sector level, the Country Integrated Development Work Plans (CIDPs) forms the basis for identifying spending priorities and underpins the budget allocations. County Fiscal Strategy Papers (CFSPs) outlining the budget are written using the Annual Development Plans (ADPs) created from CIDPs.

Planning and budgeting process at county level, showing the linkages national planning, county planning and budgeting:



Even though a robust budgeting process exists at all levels, the cMYP has not been used to inform the budget development process. This may also be due to the timeliness of its development versus the budget cycle. The County level capacity for planning, budgeting and implementation is limited, with a weak link between the immunization planning in the County Integrated Development Plans (CIDPs) and the budgets allocated and resources spent on immunization

There is need to ensure institutionalization of the use of the cMYP and the AOP to inform budgeting and to Strengthen planning and budgeting capacity at county level, (CHMT) based on the mapping of current

4. PERFORMANCE OF GAVI SUPPORT

4.1. Performance of vaccine support

Provide a succinct analysis of the performance of Gavi vaccine grants, focusing on **recently (i.e. in the last two years) introduced vaccines**, or planned to be introduced vaccines, and **campaigns**, supplementary immunisation activities (SIAs), demonstration programmes, MACs etc., as well as switches in vaccine presentations. This section should capture the following:

- **Achievements against agreed targets**, as specified in the grant performance framework (GPF), and other grant-related activity plans. If applicable, reasons why targets as specified in the GPF have not been achieved, identifying areas of underperformance, bottlenecks and risks.
- **Overall implementation progress** of Gavi vaccine support.
- **Campaigns**: Provide information on the periodicity of campaigns and key results of the post-campaign survey, including the coverage achieved. If achieved coverage was low, provide reasons. How was the operational cost support spent? Explain how the campaign contributed to strengthening routine immunisation e.g. by identifying zero-dose children and lessons learned.
- Update of the **situation analysis for measles and rubella** (using the latest immunisation coverage and surveillance data for measles, rubella and congenital rubella syndrome from national and sub-national levels¹⁰) and update of the country's **measles and rubella 5 year plan** (e.g. future dates of MR intro, MCV2 intro, follow-up campaigns, etc.).
- **Describe key actions related to Gavi vaccine support in the coming year** (e.g. decision-making on vaccine introduction, future application, planning and implementation of introduction/ campaigns) **and associated needs for technical assistance**¹¹.

The country has not had any New vaccines introductions, Supplementary Immunization Activities and or Vaccination Campaigns in the last two years

4.2. Performance of Gavi HSS support (if country is receiving Gavi HSS support) UNICEF,

- Provide a succinct analysis of the performance of Gavi's HSS support for the reporting period.
- **Progress of the HSS grant implementation** against objectives and budget, and significant deviations from plans (e.g. implementation delays, low expenditure rates, etc.), **using the below table**.
- **Achievements against agreed targets** as specified in the grant performance framework (GPF), and key outcomes. E.g. how does the number of additional children vaccinated and under-immunised children in districts supported by the HSS grant compare to other non-supported districts. Which indicators in the GPF were impacted by the activities conducted?

¹⁰ Please refer to the JA analysis guidance document for additional information on the expected analyses for measles and rubella.

¹¹ Note: When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should however describe - to the extent known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

- **Progress of the HSS grant implementation against objectives and budget, and significant deviations from plans (e.g. implementation delays, low expenditure rates, etc.), using the below table.**

UNICEF received contribution from GAVI in April 2017. The Gavi HSS Grant implementation however fully commenced in November 2017 after the government had addressed most of the issues outlined under the GMR. Implementation rate was however affected following appointment of new County staff after 2017 elections and the polio outbreak response in 12 counties, 6 of which were Gavi HSS target counties, following isolation of polio virus from the environment in April 2018. Below is summary of grant utilization on programmable funds:

In spite of the above challenges, the tables below summarizes progress of implementation against objectives and Budget. (This table is at end of section 4)

Fund utilization by Gavi HSS Objectives (November 2018)

HSS Objective	Approved Budget	Expenditure	Commitments	Unspent balance
Objective 1	168,738	93,312	49,195	75,426
Objective 2	3,265,826	1,651,216	-	1,614,610
Objective 3	1,418,730	1,044,246	212,053	374,484
Objective 4	785,700	194,078	-	591,623
MOH Coordination	86,948	133,218	-	(46,270) ¹²
UNICEF Grant Management	1,084,134	571,641	629	512,493
Grand Total	6,810,077	3,687,711	261,877	3,122,365

Over expenditure for MoH coordination was occasioned by increased engagement with counties due to appointment of new staff. The balance on Objective 2 is mainly due to savings from procurement of vehicles. The program is reviewing the expenditures and proposes to be allowed to reprogram to under budgeted activities

- **Achievements against agreed targets as specified in the grant performance framework (GPF), and key outcomes. E.g. how does the number of additional children vaccinated and under-immunised children in districts supported by the HSS grant compare to other non-supported districts. Which indicators in the GPF were impacted by the activities conducted?**

There has been tremendous improvement in Penta-3 performance in 2018 compared to what was recorded in 2017. The National coverage for the period January-October 2018 is recorded at 82%. More than half the number of counties (59%) recorded coverage of 80% and above, this is in comparison to 21% counties in 2017. All the GAVI supported counties reported coverage of above 60% for the period between January to October 2018 with 53% achieving coverage of 80% and above. Mandera has improved from 27% coverage in 2017 to 63% in the current year while Tana River has improved from 48% in 2017 to 81% in 2018. Trans Nzoia has achieved coverage of 71% in 2018 compared to a low of 46% recorded in 2017.

¹²There was an over expenditure on MOH coordination budget line caused by the need to conduct additional orientation meetings with newly appointed and elected county leadership following the 2017 elections.

Twenty seven counties reported less than 20% of unimmunized children with 9 of them being GAVI supported counties (Bungoma, Garissa, Homa Bay, Isiolo, Kitui, Meru, Nairobi, Nakuru, Tana River). Nairobi is one of the GAVI supported counties and also has the highest target population of 124,212 but has managed to achieve immunization coverage of 88% for penta-3.

- *How is Gavi support contributing to address the key drivers of low immunisation outcomes:*
 - *contributing to advancing the overall performance of the immunisation programme/service delivery structure supporting immunisation and health sector strategies;*

The Kenya Immunization program has reported stagnation in coverage in the past few years. The support from Gavi aims at addressing the increasing burden of unvaccinated. Some of the key drivers to low immunization in Kenya that are being addressed through Gavi HSS support include: limited funding by counties, distance from the health facility, health worker capacity to deliver quality services, sustained availability of vaccines at the sub-national level, demand for vaccination services and political good will.

Through Gavi HSS support the following have been accomplished that contributed to strengthening the Epi program and contributing to improved coverage in 2018 compared to 2019: High level engagement with the President to rally the country leaders to address low immunization performance, support for outreach services to underserved areas, training of frontline health workers to deliver quality services including tracking of missed children, procurement of cold chain equipment- this increased the number of immunizing health facilities as well as replacing non-functional and obsolete cold chain equipment thereby helping reduce cold chain equipment break downs, Vaccine forecasting has helped the national program and counties to plan for their vaccines to help minimize vaccine stock outs. In 2018, a total of 5,099 outreaches were conducted in the 17 priority counties. Of the children aged below 1 year reached, 9,312 received Penta 1 while 9,340 received the 3rd dose of Penta vaccine and 11,540 first dose of Measles and Rubella vaccine.

With the Procurement of utility vehicles to selected counties, transportation and distribution of vaccines from regional/ sub county depots to health facilities is expected to improve. The ongoing efforts at strengthening data quality and use, engagement of community volunteers to support immunization services and Presidential engagement on Immunization will further contribute towards better immunization outcomes in the coming year.

- *targeting districts and/or population groups with lower coverage (including in urban slums, remote rural settings and conflict settings);*

The 17 priority counties were selected based on predefined criteria which included: immunization coverage, number of unvaccinated children and multidimensional poverty index. Majority of the selected counties are those that experienced many years of under development prior to devolution and have sizeable nomadic and pastoral population that are underserved with health services and refugees from neighbouring Somalia. Nairobi county was selected because of the high numbers of unvaccinated children despite higher coverage compared to most counties, presence of urban informal settlements that are underserved, and presence of special populations (undocumented refugees and pastoral communities).

- *Addressing key barriers to coverage & equity identified in section 3 above.*

To address key barriers to coverage and equity, the Epi program engaged the highest office in the land and Ministry of Health to champion for immunization, rolled out the new WHO-UNICEF REC micro planning to guide identification of appropriate strategies to vaccinate children unable to reach health facilities due to distance and physical barriers.

- *Comment whether the selection of activities is still relevant, realistic and well prioritised in light of the situation analysis conducted, as well as financial absorption and implementation rates.*

The activities planned under HSS remain relevant though with time and based on changes over time, the

budget needs to be revised and balance of funds re allocated to underfunded priority activities identified during the Joint Appraisal including expanding support to other counties in need. The country suggest that the funding for MLM and balance of funds from procurements that have been concluded be re-allocated to expand operational level trainings and REC microplanning to non Gavi HSS counties to improve delivery of quality services. With the GAVI contribution of US\$7,354,882.40, of which US\$6,758,015 is programmable to support Immunization Health System Strengthening (HSS). Of the programmable amount, US\$3,687,711.39 has been utilized to date with US\$261,887.46 in commitments.

- Provide information on **plans to address implementation bottlenecks**, including planned budget reallocations (please attach the revised budget).

The Initial challenges with implementation was majorly due to the protracted health workers strikes, prolonged electioneering period which contributed to the appointment of new County government staff and polio vaccination campaigns. Implementation at the county level was also affected by counties delaying making requests to UNICEF due to capacity gaps for newly appointed or reassigned staffs. Moving forward, this challenge have largely been addressed and the program intends to implement the activities as per the annual implementation plan. The NVIP will share detailed budget reallocation considering the need to invest more in REC and expanding support to additional counties to train frontline health workers.

- If applicable, briefly describe the usage and results achieved with the **performance based funding (PBF)** the country received. What grant performance framework (GPF) metrics will be used to track progress?
- Briefly describe how Gavi HSS support is aligned, coordinated and **contributing to the country's health sector strategies and plans**. Mention synergies with other development partners' support.

The Kenyan government has come up with “the big 4 development agenda” to be achieved by 2022. Among these four agendas is the Universal Health Coverage which focuses on improving access to quality and affordable health services. Immunization is one of the priority intervention identified under this agenda. Gavi HSS support to the immunization program to improve coverage and reduce barriers and inequities to immunization is therefore in tandem with the achievement of universal health coverage. Through Gavi support, the Health Information system has been enabled to undertake population denominator harmonization to create harmony across all programs. The program is working with counties to create synergy with the World Bank funded “Transforming Health Systems”(THS), an initiative to counties improve reproductive, maternal, neonatal, child and adolescent health.

- (If pertinent, mention other relevant initiatives not supported by Gavi that address the key drivers of low coverage and equity.)

Implementation progress by Objective

Objective 1	
Objective of the HSS grant (as per the HSS proposals or PSR)	To accelerate strong political engagement, improve governance and financial sustainability for immunization outcomes in line with devolution by 2019
Priority geographies / population groups or constraints to C&E addressed by the objective	47 Counties National and 47 county governments are clear on their roles and responsibilities regarding management of EPI services in a devolved system Each of the 17 focus counties have at least 1 CSOs actively engaged in EPI related activities.

<p>% activities conducted / budget utilisation</p>	<p>100% as planned Budget utilization 55.3%</p>
<p>Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption</p>	<p>Engagement with counties is ongoing through the MOH, CSO and Gavi Alliance Partners-WHO and UNICEF. Financing forecast has been conducted and shared with MOH leadership. Gavi HSS program has been launched by the President of Kenya which raised the visibility of the Immunization Program. The president has unveiled the Immunization charter that outlines commitments across the two levels of government in relation to immunization services. The first lady has included immunization in her Reproductive and Maternal Health Initiative. The cabinet secretary for health has taken her role as the immunization champion and is advocating for immunization activities</p> <p>The coordinating unit is engaging to work closely with 5 counties (in the review of the county integrated development plans (CIDPs), to ensure EPI services are prioritized during planning at the county. Program visits and mentorship was conducted to all the 17 focus counties. Mapping of all CSOs in the 17 focus counties was carried out and at least one CSO actively engaged in EPI related activities. While funding for vaccines has increased from \$300,000 to \$800,000 between 2013 and 2018, funding for operational activities at both levels is still insufficient. Engagement for increased funding for immunization with counties is ongoing both through the MOH, CSO and Gavi Alliance Partners-WHO and UNICEF. UNICEF provided technical assistance to MOH for the financing forecast which has been shared with MOH management. Governors were engaged during the devolution conference in April 2018 where they were presented with immunization scorecards underscoring gaps in performance in respective counties to build a case for the need for increased financing. KANCO will have a key role in advocacy for improved funding for immunization through high level advocacy with the county and national parliamentarians. Immunization Financing Engagement Forum established in February 2018. Its overall objective is to improve coordination and synergy between government and development partners. It also has a role in establishing and maintaining an overview of relevant analytical work and advising on new and ongoing research. The Engagement Forum was inaugurated under the leadership of NVIP with +15 organizations from county to national scope. Mapping of immunization financing stakeholders has been initiated to help identify all ongoing activities and gaps in technical support that needs to be addressed by partners and GoK. UNICEF is hiring a consultant to support NVIP secretariat from January 2019.</p>
<p>Major activities planned for upcoming period (mention significant changes / budget reallocations and associated needs for technical assistance¹¹)</p>	<p>KENITAG meetings, support to select counties to anchor immunization in their county plans, high level advocacy with parliamentarians, MOH, MOF and CoG</p>
<p>Objective 2:</p>	
<p>Objective of the HSS grant (as</p>	<p>To achieve equitable access to and utilization of routine immunization</p>

per the HSS proposals or PSR)	services in 16 focus counties by 2019
Priority geographies / population groups or constraints to C&E addressed by the objective	Caregivers in the 17 focus counties are aware of and adhere to the national immunization schedule Health-workers adhere to immunization guidelines including reporting on AEFIs. All health facilities in target counties implementing micro plans to reduce numbers of unvaccinated children Difference in average Penta 3 Coverage in the 16 focus county and National is reduced
% activities conducted / budget utilisation	100% as planned Budget utilization 50.6%
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	Immunization messages targeting the caregivers have been finalized and disseminated through a meeting with all health promotion officers where these were shared. This complements interventions under KANCO to further positive impact immunization performance. Operation level training curriculum and manuals have been finalized and so far, trainings have been conducted in 9 out of the 17 GAVI focus counties, with 683 health workers and TOTs trained in EPI. The training modules include module on guidelines for reporting AEFIs. Reporting tools have also been developed and piloting completed in December 2018. National rollout is planned for first quarter of 2019. The microplanning tools have been revised. Nine out of the 17 focus counties have been trained on the module which is integrated in the operational level training. All the 630-trained health facility staff providing immunization services developed micro plans for their facilities at the end of the trainings are expected to do that annually. The sub county immunization managers will from time to time visit the health facilities to monitor implementation of the micro plans . Of the 16 plus one focus counties, Nairobi has already developed micro-plans for a subsection of their facilities (through prior GAVI support). A total of 5,099 outreaches were conducted in the 17 priority counties. Of the children aged below 1 year reached, 9,312 received Penta 1 while 9,340 received the 3 rd dose of Penta vaccine and 11,540 first dose of Measles and Rubella vaccine. The counties are still updating the data so these figures are expected to increase. There has been marked improvement in all the 14 of the 17 GAVI HSS focus counties with Tana River showing the highest improvement from 46.1% to 82.2 per cent.
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated needs for technical assistance ¹¹)	Finalization of the communication plan of action and risk communication plan, annual technical consultative forum wit professional associations, dissemination of immunization information to professional bodies, operational level training, biannual county and national supportive supervision, support immunization champions to conduct advocacy for immunization, operational level training, conduct advance EPI training The budget initially planned for MLM shall be used to conduct Advanced Epi training. This is occasioned by the review of the EPI curriculum where we now have basic, intermediate and advanced trainings in EPI.
Objective 3:	
Objective of the HSS grant (as	To strengthen immunization supply chain and logistics system (iSCL) for

per the HSS proposals or PSR)	availability of quality vaccines and immunization supplies at national and subnational levels by 2019.
Priority geographies / population groups or constraints to C&E addressed by the objective	80 per cent of immunizing health facilities have functional cold chain equipment Reduction in damage and wastage of vaccines through freeze and heat excursions Down time for cold chain equipment in the 16 focus counties reduced to less than 1month All sub counties report on stock management using the national SMT Zero HF stock outs of nationally available vaccines
% activities conducted / budget utilisation	100% of activities were conducted as planned Budget utilization 73.6%
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	The EPI fridges procured GAVI CCEOP and World Bank have facilitated 95 per cent of health facilities have adequate cold chain capacity. EPI Fridges and other cold chain equipment have been procured through the GAVI CCEOP support and distribution finalized to all the counties. Motor bikes to support all the 17 counties to strengthen the logistics and distribution of vaccines have been procured. Delivery is ongoing and completion is expected end of first quarter of 2019. Cold Chain technicians have been trained and supported to reach health facilities to repair fridges and support routine maintenance. Through KfW, Gavi and World Bank support, all Epi fridges and cold rooms have been equipped with 30 Day Temperature recording devices including the newly procured equipment. The Regional depot in Nakuru has been supported with a generator through Gavi HSS to mitigate any main line power failures. Through Gavi HSS support, 17 counties were supported to carry out preventive maintenance for their equipment. Spare parts were procured and distributed alongside the refrigerators. In 2018 a total of 100 medical engineering technicians were trained in cold chain installation, management and maintenance. The MOH is exploring strategies to better collect and utilize temperature data to guide maintenance activities more efficiently. This includes installing RTM devices at all subcounty stores, with support from Nexleaf and Gavi. Through the support from Gavi, UNICEF and CHAI, all the sub counties are reporting using the web based SMT. Continued mentorship is being provided to improve timely reporting. Stock out was reported in 5 per cent of sub-counties mainly due to National challenges in financing vaccine distribution. National Forecasting Forum was held with all the 47 counties in order to enhance capacity in forecasting and avoid stock outs in future. ISCM competencies for all EPI staff have been integrated in the Operational level training and forecasting meeting
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated needs for technical assistance ¹³)	Upgrading the stock management tool to include cold chain inventory tracking and training on its use

¹³ Note: When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should however describe - to the extent known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality

Objective 4	
Objective of the HSS grant (as per the HSS proposals or PSR)	To strengthen immunisation data management and information systems for timely decision making at national and subnational level by 2020
Priority geographies / population groups or constraints to C&E addressed by the objective	All 47 Counties Regular National and sub-national performance reviews conducted Quarterly immunization bulletin that highlight existing inequities available in all the 47 counties
% activities conducted / budget utilisation	100% Of planned activities implemented Budget utilization- 24%
Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption	DQSA tools updated. Orientation of the County Management teams completed in 2018. Performance review and denominator harmonization conducted at the national level with the 47 Counties. National Bulletin has been developed and shared with all the 47 Counties. Data Quality Self-Assessment tools revised, national level staff oriented and training for county level completed in 2018. Data Quality self assessment planned for the first quarter of 2019
Major activities planned for upcoming period (mention significant changes / budget reallocations and associated needs for technical assistance ¹⁴)	Completion of the operational M&E plan, data quality self assessment, Use community volunteers for house mapping to collect data on children under 1 year and their immunization status (to inform REC strategy)
Objective 5	MOH coordination

(embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

¹⁴ Note: When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should however describe - to the extent known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

<p>Priority geographies / population groups or constraints to C&E addressed by the objective % activities conducted / budget utilisation</p>	<p>All the implementing Counties 100% of the planned activities have been implemented Budget utilization- 153.2% This item on coordination was highly under budgeted and should therefore be considered for more funds. For the MOH Coordinating team to be functional and to properly support implementation of the project, coordination activities should be funded well</p>
<p>Major activities implemented & Review of implementation progress including key successes & outcomes / activities not implemented or delayed / financial absorption</p>	<p>Program monitoring visits to counties, on job training and county sensitization on financial management, project management and reporting. Advocacy for the project and its activities Procurement for office materials and equipment Project planning- development of national and county workplans</p>
<p>Major activities planned for upcoming period (mention significant changes / budget reallocations and associated needs for technical assistance¹⁵)</p>	<p>Project monitoring visits, Performance review, Review of the detailed implementation plan</p>

Summary of results against objectives

Results		Achievements to date
<p>Objective 1: To accelerate strong political engagement, improve governance and financial sustainability for immunization outcomes in line with devolution by 2019.</p>		
<p>Intermediate result 1</p>	<p>National and 47 county governments are clear on their roles and responsibilities regarding management of EPI services in a devolved system.</p>	<p>Engagement with counties is ongoing through the MOH, CSO and Gavi Alliance Partners-WHO and UNICEF. Financing forecast has been conducted and shared with MOH leadership. Gavi HSS program has been launched by the President of Kenya which raised the visibility of the Immunization Program. The president has unveiled the Immunization charter that outlines commitments across the two levels of</p>

¹⁵ Note: When specifying Technical Assistance (TA) needs, do not include elements of resource requirements. These will be discussed in the context of the Targeted Country Assistance (TCA) planning. The TCA planning will be informed by the needs indicated in the JA. TA needs should however describe - to the extent known to date - the type of TA required (staff, consultants, training, etc.), the provider of TA (core/expanded partner) the quantity/duration required, modality (embedded; sub-national; coaching; etc.), and any timeframes/deadlines. JA teams are reminded to both look back (TA which was not completed/successful in the past) and forward (planned vaccine introductions, campaigns, major upcoming HSS activities, etc.) when specifying TA priorities for the coming year. The TA menu of support is available as reference guide.

		<p>government in relation to immunization services. The first lady has included immunization in her Reproductive and Maternal Health Initiative.</p> <p>The coordinating unit is engaging to work closely with 5 counties (in the review of the county integrated development plans (CIDPs), to ensure EPI services are prioritized during planning at the county.</p> <p>Program visits and mentorship was conducted to all the 17 focus counties.</p>
Intermediate result 2	Each of the 17 focus counties have at least 1 CSOs actively engaged in EPI related activities.	Mapping of all CSOs in the 17 focus counties was carried out and at least one CSO actively engaged in EPI related activities.
Intermediate result 3	Sufficient funds for immunization at national and county level	<p>While funding for vaccines has increased from \$300,000 to \$800,000 between 2013 and 2018, funding for operational activities at both levels is still insufficient.</p> <p>Engagement for increased funding for immunization with counties is ongoing both through the MOH, CSO and Gavi Alliance Partners-WHO and UNICEF. UNICEF provided technical assistance to MOH for the financing forecast which has been shared with MOH management. Governors were engaged during the devolution conference in April 2018 where they were presented with immunization scorecards underscoring gaps in performance in respective counties to build a case for the need for increased financing. KANCO will have a key role in advocacy for improved funding for immunization through high level advocacy with the county and national parliamentarians.</p> <p>Immunization Financing Engagement Forum established in February 2018. Its overall objective is to improve coordination and synergy between government and development partners. It also has a role in establishing and maintaining an overview of relevant analytical work and advising on new and ongoing research. The Engagement Forum was inaugurated under the leadership of NVIP with +15 organizations from county to national scope. Mapping of immunization financing stakeholders has been initiated to help identify all ongoing activities and gaps in technical support that needs to be addressed by partners and GoK. UNICEF is hiring a consultant to support NVIP secretariat from January 2019.</p>
Objective 2: To achieve equitable access to and utilization of routine immunization services in 16 focus counties by 2019		
Intermediate result 1	Caregivers in the 17 focus counties are aware of and adhere to the	Immunization messages targeting the caregivers have been finalized and disseminated through a

	national immunization schedule.	meeting with all health promotion officers where these were shared. This complements interventions under KANCO to further positive impact immunization performance.
Intermediate result 2	Health-workers adhere to immunization guidelines including reporting on AEFIs.	Operation level training curriculum and manuals have been finalized and so far, trainings have been conducted in 9 out of the 17 GAVI focus counties, with 683 health workers and TOTs trained in EPI. The training modules include module on guidelines for reporting AEFIs. Reporting tools have also been developed and piloting completed in December 2018. National rollout is planned for first quarter of 2019.
Intermediate result 3	All health facilities in target counties implementing micro plans to reduce numbers of unvaccinated children	The microplanning tools have been revised. Nine out of the 17 focus counties have been trained on the module which is integrated in the operational level training. All the 630-trained health facility staff providing immunization services are expected to develop micro plans for their facilities by end of the year. Of the 16 plus one focus counties, Nairobi has already developed micro-plans for a subsection of their facilities (through prior GAVI support). A total of 5,099 outreaches were conducted in the 17 priority counties. Of the children aged below 1 year reached, 9,312 received Penta 1 while 9,340 received the 3 rd dose of Penta vaccine and 11,540 first dose of Measles and Rubella vaccine. The counties are still updating the data so these figures are expected to increase.
Intermediate result 4	Difference in average DPT 3 Coverage in the 16 focus county and National is reduced	There has been marked improvement in all the 14 of the 17 GAVI HSS focus counties with Tana River showing the highest improvement from 46.1% to 82.2 per cent.
Objective 3: To strengthen immunization supply chain and logistics system (iSCL) for availability of quality vaccines and immunization supplies at national and subnational levels by 2019		
Intermediate result 1	80 per cent of immunizing health facilities have functional cold chain equipment	The EPI fridges procured GAVI CCEOP and World Bank have facilitated 95 per cent of health facilities have adequate cold chain capacity.
Intermediate result 2	Reduction in damage and wastage of vaccines through freeze and heat excursions	EPI Fridges and other cold chain equipment have been procured through the GAVI CCEOP support and distribution finalized to all the counties. Motor bikes to support all the 17 counties to strengthen the logistics and distribution of vaccines have been procured. Delivery is ongoing and completion is expected end of first quarter of 2019. Cold Chain technicians have been trained and supported to reach health facilities to repair fridges and support routine maintenance. Through KfW, Gavi and World Bank support, all Epi fridges and cold rooms have been equipped with 30 Day Temperature recording devices including the newly procured

		equipment. The Regional depot in Nakuru has been supported with a generator through Gavi HSS to mitigate any main line power failures.
Intermediate result 3	Down time for cold chain equipment in the 16 focus counties reduced to less than 1month	Through Gavi HSS support, 17 counties were supported to carry out preventive maintenance for their equipment. Spare parts were procured and distributed alongside the refrigerators. In 2018 a total of 100 medical engineering technicians were trained in cold chain installation, management and maintenance. The MOH is exploring strategies to better collect and utilize temperature data to guide maintenance activities more efficiently. This includes installing RTM devices at all subcounty stores, with support from Nexleaf and Gavi.
Intermediate result 4	All sub counties report on stock management using the national SMT	Through the support from Gavi, UNICEF and CHAI, all the sub counties are reporting using the web based SMT. Continued mentorship is being provided to improve timely reporting.
Intermediate result 5	Zero HF stock outs of nationally available vaccines	Stock out was reported in 5 per cent of sub-counties mainly due to National challenges in financing vaccine distribution. National Forecasting Forum was held with all the 47 counties in order to enhance capacity in forecasting and avoid stock outs in future.
Intermediate result 6	National and county logistic staff have adequate competencies in ISCM	ISCM competencies for all EPI staff have been integrated in the Operational level training and forecasting meeting
Objective 4: To strengthen immunization data management and information systems for timely decision making at national and subnational level by 2019		
Intermediate result 1	Improved data quality assessment scores in 16 counties	DQSA tools updated. Orientation of the County Management teams completed in 2018.
Intermediate result 2	Regular National and sub-national performance reviews conducted	Performance review and denominator harmonization conducted at the national level with the 47 Counties.
Intermediate result 3	Quarterly immunization bulletin that highlight existing inequities available in the 16 focus counties	National Bulletin has been developed and shared with all the 47 Counties.
Intermediate result 4	Improved data quality assessment scores in 16 counties	Data Quality Self-Assessment tools revised, national level staff oriented and training for county level completed in 2018.

- How is Gavi support **contributing to address the key drivers of low immunisation** outcomes:
 - contributing to advancing the overall performance of the immunisation programme/service delivery structure supporting immunisation and health sector strategies;

Some of the key drivers to low immunization in Kenya include; distance from the health facility, health worker capacity to vaccinate, availability of functional cold chain equipment, availability of vaccines, demand for vaccination services and political good will

Through Gavi HSS support the following has been done:

Development of operational level training curriculum and reviewed and updated training curriculum for immunization. This has helped in providing of training materials for health workers.

Operational level training for Health workers-as of 31st November, 2018, 630 health workers have been trained. This has equipped health workers with necessary skills and developed their capacity in immunization as majority of health workers offering immunization had not been trained. It improved immunization practices as well as vaccine management.

Procurement of cold chain equipment- this increased the number of immunizing health facilities as well as replacing non-functional and obsolete cold chain equipment thereby helping reduce cold chain equipment break downs.

Vaccine forecasting has helped the national program and counties to plan for their vaccines to help minimize vaccine stock outs.

Procurement of vehicles has helped counties improve transportation and distribution of vaccines from regional/ sub county depots to health facilities.

The launch of the Gavi HSS provided a great platform for the immunization program as it was attended by H.E the president of the republic of Kenya where he also launched a 100 day RRI for accelerated immunization activities to reach the unvaccinated children. During the launch, H.E. the president also gave a directive that full immunization will be mandatory for children joining elementary school beginning 2019.

- *targeting districts and/or population groups with lower coverage (including in urban slums, remote rural settings and conflict settings);*

The 17 priority counties were selected based on predefined criteria which included: immunization coverage, number of unvaccinated children and multidimensional poverty index. Nairobi county was selected because of the urban slums, informal settlements and presence of special populations (refugees). The program employed urban micro planning to map out these special populations and reach them with vaccines through planned outreaches. The outreaches were initially conducted at fixed sites but strategy changed to household visits to reach more children based on the diversity in the areas.

In the other counties (rural) the outreaches were planned, twice per month for every supported health facility and the community was mobilized to take the children for vaccination at marked outreach sites. The outreach sites were selected based on the mapping of the hard to reach populations.

- *addressing key barriers to coverage & equity identified in section 3 above.*

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- The outreaches conducted increased access to immunization services hence more children were reached.
- The cold chain procured facilitated availability of vaccines at health facilities
- *Comment whether the **selection of activities is still relevant**, realistic and well prioritised in light of the situation analysis conducted, as well as financial absorption and implementation rates.*

The activities planned under HSS have been very relevant though with time and based on changes over time, there certain activities that need to be re programmed including:

MLM- more emphasis is being put on operational level training and therefore this activity should be re programmed so that every county (HSS non priority) is considered for at least one training.

- *Provide information on **plans to address implementation bottlenecks**, including planned budget reallocations (please attach the revised budget).*

Initial challenges with implementation was majorly due to the protracted health workers strikes and prolonged electioneering period which came to an end. Establishing a PCU also delayed and this delayed start up date for implementation. Implementation at the county level was also affected by late disbursement of funds from UNICEF based on when there requests were received and processed.

Moving forward, these challenges no longer exist and the program intends to implement the activities as per the annual implementation plan. We will also plan with counties in advance to ensure that funds are disbursed timely.

Gavi HSS activities have also been included in the NVIP strategic plan as well as the annual work plan for 2019 and therefore more focus and priority will be given to their implementation.

- *If applicable, briefly describe the usage and results achieved with the **performance based funding (PBF)** the country received. What grant performance framework (GPF) metrics will be used to track progress?*
- *Briefly describe how Gavi HSS support is aligned, coordinated and **contributing to the country's health sector strategies** and plans. Mention synergies with other development partners' support.*
- The Kenyan government has come up with the big 4 agenda and key among these four agendas is the universal health coverage which focuses on improving access to quality and affordable health services. Immunization plays a key role in the achievement of this agenda. Besides clean water and sanitation, Immunization is the most effective intervention in reducing disease burden. Gavi HSS support to the immunization program to improve coverage and reduce barriers and inequities to immunization is therefore in tandem with the achievement of universal health coverage.
- There is an opportunity to work with other partners like world bank through the Transforming Health Systems, THS, initiative, a support given to counties ton help improve reproductive, maternal, neonatal, child and adolescent health.
- *(If pertinent, mention other relevant initiatives not supported by Gavi that address the key drivers of low coverage and equity.)*

4.3. Performance of Gavi CCEOP support (if country is receiving Gavi CCEOP support)

If your country is receiving CCEOP support from Gavi, provide a brief update on the following:

- **Performance** of CCEOP indicators – achievement against agreed targets as specific in the grant performance framework (GPF);
- **Implementation status** (number of equipment installed / waiting installation, user feedback on preventive maintenance training, refrigerator performance, etc.), including any challenges / lessons learned;
- **Contribution** of CCEOP to immunisation performance;
- **Future needs for technical assistance** in implementing CCEOP support.¹¹

Note: an updated CCE inventory must be submitted together with the CCEOP renewal request.

Performance of CCEOP indicators & Implementation Status

Indicator	Baseline		Performance (CCEOP)		
	Value	Year	Year 1		
Percentage of equipped facilities replacing CCE with platform-eligible equipment	Numerator	34%	2017	Numerator	12%
	1,058			373	
	Denominator			Denominator	
	3,095			3,095	
Percentage of facilities previously without equipment, newly equipped with platform-eligible equipment	Numerator	27%	2017	Numerator	11%
	397			296	
	Denominator			Denominator	
	1,450			2,690	
Percentage of equipped facilities with functioning CCE	Numerator	80%	2017	Numerator	85%
	5,948			6,286	
	Denominator			Denominator	
	7,398			7,398	
Functional status of CCE	Numerator	92	2016	Numerator	95
	6,478			7,713	
	Denominator			Denominator	
	7,042			8,119	

The Program received 1,004 CCE under the CCEOP (535 pieces from VESTFROST SOLUTIONS and 469 pieces for B-MEDICAL SYSTEMS). These were installed in 899 sites whose health workers received PPM training. Deployment, installation and commissioning of cold chain equipment started in June 2018 and was scheduled to end in October 2018. The PMT is currently validating installation reports, obtaining user feedback on experiences with the equipment and maintenance services.

The use of service bundles offers apparent advantages including timely installations, accountability in terms of equipment handling, performance and maintenance. This relieves program officers to apply resource capacity in other areas of need. However, inadequate visibility of the work and a handsoff attitude of officers to equipment that is serviced under warranty is being experienced. In addition, the country would like to raise its concerns on the extremely high costs of the bundled package, presenting an opportunity cost for the country in accessing more cold chain equipment.

The program, through its PMT is working on strategies to monitor performance of equipment as well as the service and will continue to share lessons learned as applicable. There is need to improve coordination between the program and service providers for timely reporting and response to faults. Efforts to have feedback meetings with service providers have been put into place. Post installation, in the last two months, a number of reports of overheating with some models, faulty stabilizers etc have been reported. The bundle providers have been informed where applicable.

Impact on Immunization performance

While drawing direct correlation between cold-chain equipment availability and immunization performance might be possible, it is expected that, CCE availability will increase access to immunization services, especially where new facilities are operationalized and where capacity was expanded to allow stocking according to policy. This has increased vaccine availability at the Service Delivery Points, minimized stock outs, and missed opportunities for immunization.

Technical Assistance Needs

The PMT continues to take full charge of CCEOP implementation, and manages all CCE related activities. However, the work involved is overwhelming to a small team that has other responsibilities. The NVIP requires TA support to the PMT to verify installation checklists and update the CCE inventory

4.4. Financial management performance

- Provide a succinct review of the performance in terms of financial management of Gavi's cash grants (for all cash grants, such as HSS, PBF funding, vaccine introduction grants, campaign operational cost grants, switch grants, transition grants, etc.). This should take the following aspects into account:
- Financial **absorption** and utilisation rates on all Gavi cash support listed separately¹⁶;
- **Compliance** with financial reporting and audit requirements noting each grant (listing the compliance with each cash support grant separately, as above);
- Issues arising from review engagements (e.g. Gavi cash programme audits, or Gavi programme capacity assessments, annual external audits, internal audits, etc.) and the implementation status of any recommendations;
- Financial management **systems**¹⁷.

In the past 2 years (2017 and 2016), UNICEF received 2 grants from Gavi: MR introduction grant and HSS support.

MR Grant (OPS and NIV):

This grant was received in 2015 with expiry extended twice. The grant expired in October 2018. Through the generous contribution of **US\$13,589,500** from GAVI to the Government of Kenya (GoK) through UNICEF, a total of **US\$13,431,117.28** was utilized to successfully organize the Measles Rubella immunization campaign in May 2016 and introduce the vaccine into the routine immunization system. **US\$142,582.05** has been committed to be paid to contracted media firm. A detailed donor report has been shared with Gavi.

In 2017, UNICEF undertook document verification for all its funds (from all donors) to the MOH. Lack of accurate documentation for a portion of funds, especially those transferred to the counties was noted. UNICEF has taken action to have the MOH leadership have the funds accounted for as per the HACT policy.

Gavi HSS Grant

With the GAVI contribution of **US\$7,354,882.40**, **US\$6,758,015** is programmable to support Immunization Health System Strengthening (HSS). Of the programmable amount, **US\$3,687,711.39** has been utilized to date with **US\$261,887.46** in commitments. A detailed donor report has been shared with Gavi. Spot check at MOH National did not reveal any non-compliance with UNICEF policy. UNICEF is working closely with the HSS coordinating unit to ensure accountability of funds by Counties. Currently 1 county is not being directly funded due to audit findings that the county is addressing.

4.5. Transition planning (if applicable, e.g. country is in accelerated transition phase)

If your country is transitioning out of Gavi support, specify whether the country has a transition plan in place. If no transition plan exists, please describe plans to develop one and other actions to prepare for transition.

- *If a transition plan is in place, please provide a brief overview on the following:*
 - *Implementation progress of planned activities;*
 - *Implementation bottlenecks and corrective actions;*
 - *Adherence to deadlines: are activities on time or delayed and, if delayed, the revised expected timeline for completion;*
 - *Transition grant: specify and explain any significant changes proposed to activities funded by Gavi through the transition grant (e.g., dropping an activity, adding a new activity or changing the content/budget of an activity);*
 - *If any changes are requested, please submit a consolidated revised version of the transition plan.*

UNICEF is currently managing Gavi funds on behalf of the country, for an interim period, pending the strengthening of MoH fiduciary systems as required by Gavi. During this period, it is expected that UNICEF provides support in building a functional grant management system at MoH as per the GMRs.

¹⁶ If in your country Gavi funds are managed by partners (i.e. UNICEF and WHO), fund utilisation by these agencies should also be reviewed.

¹⁷ In case any modifications have been made or are planned to the financial management arrangements please indicate them in this section.

Kenya entered the preparatory transition phase in January 2016. The country is expected to enter the accelerated transition phase in 2022. The Ministry of Health continues to work with the National Treasury in preparation for this transition. The country is in the formative stages of developing a transition plan.

In order to develop the plan, some preparatory activities have been conducted, while some are underway:

- Various 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 have been done, with recommendations on approaches and or opportunities for commercial financing of vaccines
- Engagement of stakeholders (Ministry of Finance, Parliamentarians, CSOs, Development Partners, Private sector etc.) to advocate for sustainable financing and resources for immunization
- Setting up a Domestic Resource Mobilization for Health workshop, a joint National Health Financing Dialogue for Implementation of the Health Sector Domestic Financing Sustainability Plan for HIV, TB, Immunization, and Malaria
- Developing a National Immunization Strategic Plan (cMYP) reflecting the additional obligations and providing for alternative sources of sustainable financing

An Immunization Financing thematic group is being set up, that will map out all stakeholders involved in this field in Kenya in order for the country to better capitalize on the partners' respective positioning and activities at national, regional and local levels, creating synergies and efficiencies and to consolidate their efforts in immunization financing work in preparation for the transition. Further, a Joint Action Plan and streamlined coordination framework will be generated with clearly identified short term and long term activities for all Immunization financing actors, feeding into the existing immunization governance structures in the country

While important progress was made in the first quarter of 2018, very little progress has been made so far. The insufficient progress in the second quarter of 2018 can be partly explained by competing priorities largely related to Polio and Measles outbreaks in the country. The country has prioritized transition planning in the coming year.

• **Technical Assistance (TA)**

- *Describe the strategic approach to Technical Assistance (TA) delivery to improving coverage and equity in reaching the under-immunised and unimmunised children. (i.e. embedded support, subnational support, support from expanded partners etc.)*
- *On the basis of the reporting against PEF functions and milestones, summarise the progress of partners in delivering technical assistance.*
- *Highlight progress and challenges in implementing the TA plan.*
- *Specify any amendments/ changes to the TA currently planned for the remaining of the year.*

During the period under reporting, immunization partners provided technical support to Ministry of Health immunization programme with the objective of increasing immunization coverage, reducing the number of under/unvaccinated children and addressing immunization inequities. The key partners that provided technical and funding support include World Health Organization (WHO), UNICEF, CHAI, JSI, PATH among other partners. Various immunization partners provided support in several areas of immunization such as leadership, building capacities of institutions and human resources on

immunization, vaccine management, data quality improvement, introduction of new and underutilized vaccines and communication. The technical support resulted in improvement in immunization coverage, although disparities among counties still exist and persistent, unresolved challenges remain. These challenges have been enhanced with the deployment of new health managers at county and sub-county level following the reconstitution of County Governments following the August 2017 General Elections and October 2017 Presidential elections. The progress is highlighted in the subsequent paragraphs.

WHO provided technical support in areas of coverage and equity, leadership, management and coordination, vaccine support and data quality whereas UNICEF provided support in the areas coverage and equity, supply chain, demand generation and immunization financing. Technical support of WHO was provided both at national and county levels. At the national level, support was provided by 6 technical officers based at WHO Kenya country office and one officer embedded in KEMRI laboratory, whereas 5 immunization/surveillance officers supported the County levels. The areas for targeted technical support at county level was prioritized based on need informed by immunization and surveillance gaps, presence of vaccine preventable outbreaks and human resource skill gaps. WHO field presence at sub-national level was augmented by STOP polio consultants. Deployment of WHO immunization and surveillance officers and STOP polio consultants to prioritized counties to provide technical support was informed by analysis on immunization performance and geographical variations of the counties.

In collaboration with other immunization partners, WHO led the implementation of prevalidation assessment and validation survey. Following the validation survey that was carried out in February 2018, Kenya was validated to have eliminated MNT. In planning WHO spearhead and coordinated the implementation of comprehensive Immunization programme review that was conducted in June 2018. The review identified areas of programme strengths, challenges and generated recommendations that were documented and prioritized to inform the next planning phase. The draft costed Kenya comprehensive multiyear plan for immunization (cMYP) was developed informed by EPI programme review recommendations which prioritized investment areas for the next 5 years

As part of the wider strategy to address inequities in order to increase coverage, WHO through its field presence, identified areas with capacity gaps and poor performance in immunization and surveillance for targeted for support. Areas of low coverage, large number of under-vaccinated children and VPD outbreaks were identified and the WHO field staff deployed to build their capacity. Subnational health staff trained, mentored, sensitized and oriented on immunization and vaccine preventable disease surveillance. From January to November 2018, 304 visits were conducted by 5 field-based WHO staff. 35 counties, 103 sub counties and 277 H/Fs were visited. The findings from the field visits were documented using open data kit (ODK) integrated immunization support supervision (ISS). 38% health facilities visited were dispensaries, 25% were sub-county hospitals, 19% health centres, 8% county hospitals, 6% private health facilities, 4% faith based and 1% teaching hospital. UNICEF, Continued expansion of implementation of REC strategy in 4 focus counties and engaged 60% of target health facilities and also carried out operational level training in 1 of 4 counties. Training in 3 counties planned for 1st quarter of 2019. Immunization improvement plan for Nairobi county due for stakeholder review was delayed by polio vaccination response. Furthermore UNICEF supported training of National EPI, HMIS and 6 counties on GIS tools. Maps were developed to address gaps in HF Geo-coding in DHIS2 as part of GIS support.

To support the immunization programme, WHO facilitated immunization data analysis to inform action and feedback of performance by county and sub-county. A template for the quarterly and annual immunization bulletin was designed and tested as a medium for documentation and dissemination of immunization performance in order to improve data quality by closing the feedback loop. The performance was inbuilt in the immunization annual work plans and deployment of technical support which resulted to improved ownership of programme at county level. In order to address denominator challenges, WHO convened Consultative forum held in July and August 2018: National vaccines and immunization programme (NVIP), Health Information Systems (HIS) division, Kenya National Bureau of Statistics (KNBS) and Counties. The forum resulted in harmonized denominators harmonized which was used to revise annual immunization targets

In order to address immunization coordination challenges, WHO provided support to re-establish, institutionalize and convene the immunization coordination mechanism and oversight/advisory bodies. Immunization interagency coordination committee (ICC) was constituted in September 2017 while the Kenya National Vaccine Safety Advisory Group (KNVSAC) in 2018. Immunization technical working groups and immunization committees such as monitoring and evaluation were operationalized. These fora provided an opportunity to bring immunization partners together, reduce duplication and promoted synergy among the immunization partnership. The vaccine safety strategy was developed and the Kenya National Vaccine safety committee (KNVSAC) established to review causality of AEFIs and to build public confidence and reduce negative publicity. KNVSAC is also a requirement for Malaria Vaccine pilot pharmacovigilance.

For Kenya to access new vaccines and to reduce the number of under vaccinated children against measles and rubella (MR), WHO in collaboration with other partners, supported the drafting of Kenya's application for nationwide Measles Rubella (MR) follow up supplemental immunization activity (SIA) which was approved by Gavi. 7,253,043 children aged 9-59months are planned to be reached with MR in 2019 through a nation-wide vaccination with MR vaccine. The last MR catch up vaccination campaign was carried out in 2016 reaching >95% children aged 9months to 14 years. Further, WHO supported the drafting and submission of applications to Gavi for nation-wide HPV introduction, MenafriVac vaccination in 5 high risk counties bordering South Sudan and Ethiopia and Yellow fever introduction in Turkana and West Pokot planned for 2019. It is estimated that 3,116,626 persons 1-29 years will be reached with MenafriVac vaccine in the Counties of West Pokot, Turkana, Marsabit, Mandera and Wajir whereas 55,737 children will be vaccinated every year with yellow fever vaccine. The nationwide introduction HPV vaccine approved by Gavi is expected to reach 3.2million girls with HPV vaccine every year. The introduction of HPV was delayed by global vaccine supply constraints and is now planned to be introduced in 2019.

In collaboration with other partners to improve supply chain and logistics, UNICEF supported the Supply Chain and Logistics working group and PMT, conducting of EVM Self-assessment at CVS and Regional Stores, adoption of WHO SMT, consistent use of ViVa, temperature monitoring study and training of 84 cold chain technicals on equipment installation and maintenance. UNICEF also provided support for CCEOP and WB equipment procurement, delivery and installation.

So as to inform communication planning, UNICEF supported implementation of knowledge attitude and practice surveys in 17 counties. The assessment informed development of 4 county communication plans and development of hard to reach audience strategy (for Nomads, for IDPs and Refugees, for high density urban populations and for hard to reach religious groups) fulfilling the equity agenda

In order to generate demand for vaccines, UNICEF supported engagement of a creative agency to develop advocacy and branding of new IEC materials and documentary for Routine Immunization as well as engagement and consultative forums with Health journalists for promotion of immunization. Further engagement with national and community radio stations was done. 88 Teachers and 2,585 school children in Narok and Kisii oriented in strategy and are tracking and following up missed children. So far, 7,952 children under 1 have been registered. This activity is directly linked to defaulter tracing in particular communities. The routine immunization champion was featured on BBC <https://www.youtube.com/watch?v=giE7641JIPY>. Continuous capacity building and community empowerment is ongoing. Front line health workers from 16 counties were trained on interpersonal communication skills and job aids to support CHVs in community mobilization developed. As part of crisis communication, risk communication guidelines were developed for use at the national and county level. Risk communication strategy to address adverse events in relation to the Polio Campaigns and social media tracking with real time response was implemented

UNICEF supported advocacy with Cabinet Secretary (CS) for bundling of vaccines and devices at National level, establishment and support to immunization financing forum and assessment of County Planning and Budget planned for 2019-results will inform development of tools for immunization financial tracking.

Despite the good progress, the scope of the technical support is constrained by various challenges which include the following:

- Sustaining the gains made so far in the immunization programme
- Health system bottlenecks e.g. human resource shortage at the national immunization programme and counties
- Frequent turn over and attrition of MOH human resources
- Inadequate financial resources to support the country immunization programme
- Limited amount of catalytic funding for activities under TCA
- Inadequate human resource among immunization partners to effectively provide support at national and county level given the unique Kenya structure that health service delivery including vaccination is a fully devolved function.

5. UPDATE OF FINDINGS FROM PREVIOUS JOINT APPRAISAL

Provide the status of the prioritised strategic actions identified in the previous Joint Appraisal¹⁸ and any additional significant Independent Review Committee (IRC) or High Level Review Panel (HLRP) recommendations (if applicable).

Prioritised actions from previous Joint Appraisal	Current status
Review meetings with utilization of data for decision making not regularly done both at the county and facility levels	In Progress
Standard feedback to peripheral level on status of immunization coverage, completeness and timeliness of reporting.	In Progress
Capacity building for health workers	In Progress
Provision of updated tools	In Progress
Reporting tool on AEFI	In Progress
Data Triangulation	In Progress
Monitoring of KPIs	In Progress
Supportive supervision	In Progress
Data quality self assessment	In Progress
Strengthening of capacity building for surveillance	In Progress
Active case search	Complete
Support supervision for surveillance and feed back	Complete
Additional significant IRC / HLRP recommendations (if applicable)	Current status
Vaccine supply, cold chain and logistics (2017) <ol style="list-style-type: none"> a) Training of supply chain officers on vaccine management b) Logistical and technical support for the cold chain Project Management Team (PMT) c) Improve visibility of supply chain data to facilitate timely decision making d) Conduct supply chain data review meetings (county and national) & Design and develop SOPs to improve vaccine management 	<ol style="list-style-type: none"> a) Pending due to application deadlines b) Technical support availed. Logistical support?? c) Chanjo® utilization is at 70% at sub-county level. ViVA (ordering and shipment planning) and WHO SMT being used at national level d) a. Supply chain data review

¹⁸ Refer to the section "Prioritised Country Needs" in last year's Joint Appraisal report

	meetings in 11 counties (IMPACT teams) b. SOPs have been drafted
2. Vaccine supply, cold chain and logistics (2016) a) Improve cold chain performance and temperature monitoring through refresher training on temperature monitoring and response by facility first responders at facility level. b) Carry out a follow up EVM Assessment 2017	a) HSS Operational Level Training for 17 counties is on-going (get the number trained) b) EVM self-assessment was conducted
3. ACSM	
KAP Studies conducted in 20 low performing counties	100% completed
Development of CHV guidelines	99% complete
National communication plan and crisis/risk communication plan developed	99% complete
IPC ToT training for health workers	100% completed
IPC ToT training for CHVs	Not done
Implementing a crisis communication plan for campaigns	100%
Mobilization of immunization ambassadors	Not done
Working across sectors with Ministry of Education and religious bodies to address hesitancy	On going
FGDs and Community dialogue meetings on vaccine preventable diseases, the need to complete immunization schedule, vaccine being given, benefits and side effects if any	Not done
Stakeholder engagement(professionals, religious leaders, CSOs, Political leaders, alternative medicine	On going
Sharing information on mass media and digital platforms	On going
Development of RI documentary(TCA 2018)	Not done
Engagement of Primary Schools in RI(TCA 2018)	Not done

If findings have not been addressed and/or related actions have not taken place, provide a brief explanation and clarify whether this is being prioritised in the new action plan (section 6 below).

6. ACTION PLAN: SUMMARY OF FINDINGS, ACTIONS AND RESOURCE/SUPPORT NEEDS IDENTIFIED AND AGREED DURING THE JOINT APPRAISAL

*Briefly summarise the **key activities to be implemented next year** with Gavi grant support, including if relevant any introductions for vaccine applications already approved; preparation of new applications, preparation of investment cases for additional vaccines, and/ or plans related to HSS / CCEOP grants.*

*In the context of these planned activities and based on the analyses provided in the above sections, describe the five **highest priority findings and actions to be undertaken to enhance the impact of Gavi support or to mitigate potential future risks to programme and grant performance.***

Please indicate if any modifications to Gavi support are being requested, such as:

- *Changes to country targets as established earlier, either from the agreed Grant Performance Framework (GPF) or as part of the NVS renewal request submitted by 15 May;*
- *Plans to change any vaccine presentation or type;*
- *Plans to use available flexibilities to reallocate budgeted funds to focus on identified priority areas.*

<p>Key finding 1</p>	<p>Demand generation: There is general acceptance of vaccination services in the communities, communication focal persons at sub-national levels and Community Health Volunteer structure in place. However, the national communication strategy is yet to be disseminated and adapted at sub-national levels, existing vaccine hesitancy and refusals in sections of the community, inadequate capacity of the healthworkers to communicate with caregivers on immunization and poor access to information on immunization by the communities leading to misconceptions.</p>
<p>Agreed country actions</p>	<ol style="list-style-type: none"> 1. Disseminate and Implement national /risk communications plan and CHV guidelines to counties 2. Support coordination of National Demand Creation Activities- Thematic group, Implementation and Monitoring of a common Demand Generation Road map 3. Scale up strategies to increase immunization program visibility and increase access to information through mass media and penetration of social networks to boost public demand for immunization, increase awareness and public trust 4. Implement interventions aimed at increased acceptance, reduced vaccine hesitancy and refusals in new vaccines introductions and campaigns- HPV, Yellow Fever, Men A, Measles Rubella 5. Develop a reporting system/tool for ACSM RI activities(M&E Workshop) 6. Develop and implement strategies to engage Primary Schools on RI, including development and dissemination of immunization IECs
<p>Associated timeline</p>	<p>By December 2019</p>
<p>Technical assistance needs</p>	<p>Technical assistance needed to:</p> <ol style="list-style-type: none"> 1. Implement sustainable strategies to increase Program Visibility and Access to information by the communities through electronic mass media and social networks 2. Develop a strategy and tools to engage Primary Schools on RI
<p>Key finding 2</p>	<p>M&E and Data Management RI coverage monitoring system well established, using DHIS2 with good data management practices. However, Poor data quality at Health Facility Level, inadequate capacity to analyze and use data for decision-making and corrective actions, lack of performance review at sub-national levels, Inadequate support supervision and lack of SoPs to guide data management exist</p>
<p>Agreed country actions</p>	<ol style="list-style-type: none"> 1. Use of technology & Innovations to improve data quality- GIS mapping & EVRs 2. Support to Quarterly National Immunization Data Review, Harmonization and Target Setting 3. Finalize and Disseminate Immunization M& E framework and Data SoPs 4. Review and Implement a National Immunization Data Quality Improvement Plan 5. Support to improve the design, and disseminate national immunization bulletin and National Immunization Score card and institutionalization of the same 6. Support to Follow up for Sub-national level reporting to improve Data Quality
<p>Associated timeline</p>	<p>By December 2019</p>
<p>Technical assistance needs</p>	<p>Technical assistance needed to:</p> <ol style="list-style-type: none"> 1. GIS for equity programming 2. Develop the Immunization M&E Framework
	<p>Governance, Sustainable immunization financing and New Vaccine Introduction – Continued political commitment, Coordination Platforms in Place. However,</p>

7. JOINT APPRAISAL PROCESS, ENDORSEMENT BY THE NATIONAL COORDINATION FORUM (ICC, HSCC OR EQUIVALENT) AND ADDITIONAL COMMENTS

- *Does the national Coordination Forum (ICC, HSCC or equivalent) meet the Gavi requirements (please refer to <http://www.gavi.org/support/coordination/> for the requirements)?*
- *Briefly describe how the Joint Appraisal was reviewed, discussed and endorsed by the relevant national Coordination Forum (ICC, HSCC or equivalent), including key discussion points, attendees, key recommendations and decisions, and whether the quorum was met. Alternatively, share the meeting minutes outlining these points.*
- *If applicable, provide any additional comments from the Ministry of Health, Gavi Alliance partners, or other stakeholders.*

In the course of 2018, The National Vaccines and Immunization Program, with support from in-country partners set out to set up working groups focused on thematic areas. These groups comprising the program, state and non state immunization stakeholders jointly mapped their current initiatives and support to immunization by thematic area, with an ultimate objective of aligning these, creating synergies, efficiencies and maximizing on available resources. They established coordination mechanisms centered on their thematic areas and developed common plans of action.

In October 2018, members of the immunization TWG and other immunization stakeholders started a series of meetings to develop a new National Immunization Strategic Plan (cMYP), and prepare for the Joint Appraisal. Teams were constituted as per thematic area to populate the Joint Appraisal template. Teams were constituted for the following areas:- Governance, Program Management and Financing; Monitoring, Evaluation and Surveillance; Service Delivery, Capacity Building, Coverage & Equity; Vaccine Supply and Quality; Demand Creation

The teams were tasked to ensure they collate all the information required for the JA, review the previous JA and highlight the progress on the key areas planned as per the 2017 JA. The teams would also identify in brief, based on recent program reviews and assessments, the country's strategic direction and global obligations the potential areas that needed intervention in the following year. The teams constituted of members from the MOH-NVIP, MOH health promotion, MOH Finance, MOH DSRU, WHO, UNICEF, CHAI, CDC, KANCO, Living Goods, HENNET, JSI, USAID, American Redcross, Kenya Redcross, JKUAT. Sections of the JA template were assigned to teams. Once populated, these were collated into one document which was circulated for review

During this process the following key documents were utilized in developing the 2016 JA; JA analysis guidance, Guidelines on reporting and renewal, the JA template, Draft National Immunization Strategic Plan document, Comprehensive EPI Review 2018, Measles-Rubella Post SIAs coverage survey and Post Introduction Evaluation, KDHS 2014, The GAVI TCA, Draft KHSSP 2018-2022, WHO-UNICEF JRF, EVM assessment of 2014, DHIS reports, Data Quality Improvement Plans, NVIP work plans and reports, and NVIP field supervision reports among others.

The country then held its Joint Appraisal workshop 27th-30th November 2017. Participants were drawn from the Ministry of Health and in-country partners as well as technical partners from outside the country. Participants included: MOH, WHO, UNICEF, CHAI, CDC, WB, KANCO, CRS, HENNET, SABIN, JSI, USAID, DFID, LIONS, DPHK, GAVI, AMERICAN RED CROSS, APHRC, SABIN.

A preparatory workshop was followed by the JA workshop in which members reviewed the draft report specifically the country context and performance as well as progress in implementing the 2017 JA recommendations. Members then reviewed key drivers of low coverage and equity as per the thematic areas and provided an action plan for the JA 2018, taking into consideration pending activities planned in the last JA, activities in the HSS and on-going partner and MOH activities. The team provided feedback to the Chief Administrative Secretary, Health and the N-ICC on 10th January. The CAS reiterated commitment of the Ministry of Health to achieve all objectives as set out in the JA.

On 10th January 2019 the National Immunization Coordinating Committee met and endorsed the Joint Appraisal 2018.

8. ANNEX: Compliance with Gavi reporting requirements

Please confirm the status of reporting to Gavi, indicating whether the following reports have been uploaded onto the Country Portal. **It is important to note that in the case that key reporting requirements (marked with *) are not complied with, Gavi support will not be reviewed for renewal.**

	Yes	No	Not applicable
Grant Performance Framework (GPF) * reporting against all due indicators			
Financial Reports *			
Periodic financial reports			
Annual financial statement			
Annual financial audit report			
End of year stock level report (which is normally provided by 15 May as part of the vaccine renewal request) *			
Campaign reports *			
Supplementary Immunization Activity technical report			
Campaign coverage survey report			Yes
Immunisation financing and expenditure information			Yes
Data quality and survey reporting			
Annual data quality desk review			
Data improvement plan (DIP)	Draft cMYP		
Progress report on data improvement plan implementation			
In-depth data assessment (conducted in the last five years)	DQA done		N/A
Nationally representative coverage survey (conducted in the last five years)	Yes (KDHS)		
Annual progress update on the Effective Vaccine Management (EVM) improvement plan			
CCEOP: updated CCE inventory			
Post Introduction Evaluation (PIE)			
Measles & rubella situation analysis and 5 year plan			
Operational plan for the immunisation programme			
HSS end of grant evaluation report			
HPV specific reports			
Reporting by partners on TCA and PEF functions			

In case any of the required reporting documents is not available at the time of the Joint Appraisal, provide information when the missing document/information will be provided.

ⁱ Source: WHO Global Health Expenditure Database (GHED) <http://apps.who.int/nha/database> (Last update: December 13, 2018). Accessed 14.12.2018