Application Form for Gavi NVS support

Submitted by

The Government of

Kenya

Date of submission: **26 May 2017**

Deadline for submission:

i. **3 May 2017**
ii. 3 May 2017
iii. 1 September 2017

Select Start and End Year of your Comprehensive Multi-Year Plan (cMYP)

Start Year	2015	End Year	2019

Form revised in 2016

(To be used with Guidelines of December 2016)

Note: Please ensure that the application has been received by Gavi on or before the day of the deadline.

Gavi
GRANT TERMS AND CONDITIONS

FUNDING USED SOLELY FOR APPROVED PROGRAMMES

The applicant country ("Country") confirms that all funding provided by the Gavi will be used and applied for the sole purpose of fulfilling the programme(s) described in the Country's application. Any significant change from the approved programme(s) must be reviewed and approved in advance by the Gavi. All funding decisions for the application are made at the discretion of the Gavi Board and are subject to IRC processes and the availability of funds.

AMENDMENT TO THE APPLICATION

The Country will notify the Gavi in its Annual Progress Report if it wishes to propose any change to the programme(s) description in its application.The Gavi will document any change approved by the Gavi, and the Country's application will be amended.

RETURN OF FUNDS

The Country agrees to reimburse to the Gavi all funding amounts that are not used for the programme(s) described in its application. The country's reimbursement must be in US dollars and be provided, unless otherwise decided by the Gavi, within sixty (60) days after the Country receives the Gavi's request for a reimbursement and be paid to the account or accounts as directed by the Gavi.

SUSPENSION/ TERMINATION

The Gavi may suspend all or part of its funding to the Country if it has reason to suspect that funds have been used for purpose other than for the programmes described in the Country's application, or any Gavi-approved amendment to the application. The Gavi retains the right to terminate its support to the Country for the programmes described in its application if a misuse of Gavi funds is confirmed.

ANTICORRUPTION

The Country confirms that funds provided by the Gavi shall not be offered by the Country to any third person, nor will the Country seek in connection with its application any gift, payment or benefit directly or indirectly that could be construed as an illegal or corrupt practice.

AUDITS AND RECORDS

The Country will conduct annual financial audits, and share these with the Gavi, as requested. The Gavi reserves the right, on its own or through an agent, to perform audits or other financial management assessment to ensure the accountability of funds disbursed to the Country.

The Country will maintain accurate accounting records documenting how Gavi funds are used. The Country will maintain its accounting records in accordance with its government-approved accounting standards for at least three years after the date of last disbursement of Gavi funds. If there is any claims of misuse of funds, Country will maintain such records until the audit findings are final. The Country agrees not to assert any documentary privilege against the Gavi in connection with any audit.

CONFIRMATION OF LEGAL VALIDITY

The Country and the signatories for the Country confirm that its application, and Annual Progress Report, are accurate and correct and form legally binding obligations on the Country, under the Country's law, to perform the programmes described in its application, as amended, if applicable, in the APR.

CONFIRMATION OF COMPLIANCE WITH THE Gavi TRANSPARENCY AND ACCOUNTABILITY POLICY

The Country confirms that it is familiar with the Gavi Transparency and Accountability Policy (TAP) and complies with the requirements therein.

USE OF COMMERCIAL BANK ACCOUNTS

The Country is responsible for undertaking the necessary due diligence on all commercial banks used to manage Gavi cash-based support. The Country confirms that it will take all responsibility for replenishing Gavi cash support lost due to bank insolvency, fraud or any other unforeseen event.

ARBITRATION

Any dispute between the Country and the Gavi arising out of or relating to its application that is not settled amicably within a reasonable period of time, will be submitted to arbitration at the request of either the Gavi or the Country. The arbitration will be conducted in accordance with the then-current UNCITRAL Arbitration Rules. The parties agree to be bound by the arbitration award, as the final adjudication of any such dispute. The place of arbitration will be Geneva, Switzerland

. The languages of the arbitration will be English or French.

For any dispute for which the amount at issue is US$ 100,000 or less, there will be one arbitrator appointed by the Gavi. For any dispute for which the amount at issue is greater than US $100,000 there will be three arbitrators appointed as follows: The Gavi and the Country will each appoint one arbitrator, and the two arbitrators so appointed will jointly appoint a third arbitrator who shall be the chairperson.

The Gavi will not be liable to the country for any claim or loss relating to the programmes described in the application, including without limitation, any financial loss, reliance claims, any harm to property, or personal injury or death. Country is solely responsible for all aspects of managing and implementing the programmes described in its application.

1. Type of Support requested

Please specify for which type of Gavi support you would like to apply to.

Type of Support	Vaccine	Start Year	End Year	Preferred second presentation[1]
Routine New Vaccines Support	HPV quadrivalent, 1 dose(s) per vial, LIQUID	2018	2018	HPV bivalent, 2 dose(s) per vial, LIQUID
Preventive Campaign Support	Meningococcal A, 10 dose(s) per vial, LYOPHILISED	2018	2018	Not applicable

[1] Gavi may not be in a position to accommodate all countries first product preferences, and in such cases, Gavi will contact the country and partners to explore alternative options. A country will not be obliged to accept its second or third preference, however Gavi will engage with the country to fully explore a variety of factors (such as implications on introduction timing, cold chain capacity, disease burden, etc.) which may have an implication for the most suitable selection of vaccine.

2. Table of Contents

3. Executive Summary

Please provide a summary of your country's proposal, including the following the information:

- For each specific request, NVS routine support or NVS campaign :
  - The duration of support
  - The total amount of funds requested
  - Details of the vaccine(s), if applicable, including the reason for the choice of presentation
  - Projected month and year of introduction of the vaccine (including for campaigns and routine)

- Relevant baseline data, including:
  - DTP3 and Measles coverage data (as reported on the WHO/UNICEF Joint Reporting Form)
  - Target population from Risk Assessments from Yellow Fever and Meningitis A
  - Birth cohort, targets and immunisation coverage by vaccines

- Country preparedness
  - Summary of planned activities to prepare for vaccine launch, including EVM assessments, progress on EVM improvement plans, communication plans, etc.
  - Summary of EVM assessment and progress on EVM improvement plan

- The role of the Coordination Forum (ICC/HSCC or equivalent) and stakeholders' participation (e.g. government, key donors, partners, key implementers, CSOs) in developing this proposal

Cervical cancer is the second most common cancer and the leading cause of cancer deaths in Kenya. It is estimated that every year 4,802 women in the country are diagnosed with the disease, and about 2,451 cervical cancer deaths occur annually in Kenya (HPV Information Centre estimations 2012). At present, approximately 10.3 million women aged above 15 years are at risk of developing the disease. Unless concerted efforts are made to prevent and control the disease, it is projected that the incidence of cervical cancer will rise to 4261 cases per year with 2955 (69%) annual deaths by the year 2025. Ministry of Health through the National Vaccines and Immunization Program plans to introduce the HPV vaccine into the national routine immunization program in January 2018 as a preventive measure against cervical cancer. The target population will be girls aged 10-14 years old in the year of introduction, and girls aged 10 years in subsequent years.

About 1.5 million surviving infants are targeted for routine immunization every year. The 2016 population in Kenya is estimated at 45,367,322 with live births 1,591,167, surviving infants 1,514,775. In the year 2016, the coverage for the third dose of Pentavalent vaccine was 78% while that of Measles first dose was 71% (Draft JRF 2016). A HPV vaccine demonstration pilot was successfully conducted in Kitui County in May 2013-May 2015 with a coverage of 86%.

On the other hand, the northern part of Kenya falls within the meningitis belt, making Kenya one of the countries at risk for outbreaks of serogroup A meningococcal disease. Kenya has experienced outbreaks of meningococcal disease in the past years. Notably, Turkana and West Pokot counties, have experienced outbreaks of meningococcal disease in the last decade. West Pokot County borders Uganda while Turkana County borders Uganda, South Sudan and Ethiopia. Additional border counties that are at risk of meningococcal A disease include Marsabit (bordering Ethiopia), and Mandera and Wajir (both bordering Ethiopia and Somali). The fourth objective of the African Region Immunization Strategic Plan requires that all countries in the meningitis belt introduce the Neisseria meningitidis serogroup A conjugate vaccine (MenAfriVac). Two analyses of epidemiologic data and risk assessment have been conducted in Kenya using the District Prioritization Tool (DPT) – one in 2014 and another in 2016. Experts strongly recommended the introduction of the vaccine through mass immunization campaigns in 5 counties (Wajir, Turkana, West-Pokot, Mandera, Marsabit) which share international borders with countries where meningitis epidemics have recently occurred. Kenya is planning to conduct a mass campaign in these 5 border counties targeting

approximately 3 million persons aged 1-29 years old with the MenAfriVac vaccine in February 2018.

Kenya enjoys a Partnership with Gavi that has facilitated introduction of new vaccines including Pentavalent, PCV, Rota Virus, IPV and Measles Rubella. This proposal is a detailed request to Gavi to support introduction of HPV vaccine in routine immunization nationally and the introduction of Meningococcal A vaccine through mass campaign in five high risk counties (Mandera, Wajir, Turkana, West Pokot and Marsabit).

In order to introduce the HPV vaccine nationally, the country is requesting Gavi for support in the form of:

- Vaccines, safety boxes, syringes
- Operational support for 2018 totaling to $3,196,241 for the year 2018. Operational support will be key in preparation and implementation HPV vaccination particularly:
    - Planning and Coordination
    - Advocacy and social mobilization including development of a communication plan
    - Service delivery including capacity building and outreach
    - Vaccine and logistics supply management
    - Waste management
    - Monitoring and evaluation

In addition, for HPV vaccine Kenya will be required to contribute its co-financing portion of $498,823 for vaccines for the routine cohort by June 2019.

To conduct the meningococcal vaccination campaign, the country is requesting support in the form of

- Vaccines, syringes, safety boxes
- Operational support totaling to $ 2,025,787 for campaign preparation and implementation in the following key areas:
    - Planning and Coordination
    - Advocacy and social mobilization
    - Service delivery including capacity building
    - Vaccine and logistics supply management
    - Waste management
    - Monitoring and evaluation
    - strengthening meningococcal surveillance

The country is on track implementing the EVMA 2013 recommendations. The country is planning to increase cold chain capacity through the CCEOP and through advocating for increased immunization financing especially at county level. Kenya has also introduced an electronic logistics management information system that will improve vaccine stock management. The country is also leveraging on the upcoming Gavi HSS support to improve immunization outcomes through activities such as capacity building and outreaches

This proposal has been developed by the National Immunization Technical Working Group led by the EPI Manager. The TWG is accountable to the Child Health Interagency Coordination Committee (CH-ICC) which is chaired by the Director of Medical Services. Membership to the TWG consists of program leads at the Ministry of Health (National Vaccines and Immunization Program, Reproductive and Maternal Health Services Unit, Neonatal Child and Adolescent Health Unit) from the partner organizations (WHO, UNICEF, CHAI, USAID-MCSP), and CSO (HENNET, KENCO, KANCO). In September 2016, the ICC endorsed plans for introduction of national HPV vaccination. This proposal was endorsed by the ICC on 13th April 2017. The Kenya National Immunization Technical Advisory Group (KENITAG) also recommended introduction of national HPV vaccination.

4. Signatures

4.1. Signatures of the Government and National Coordinating Bodies

4.1.1. Government and the Inter-Agency Coordinating Committee for Immunisation

The Government of Kenya would like to expand the existing partnership with the Gavi for the improvement of the infants routine immunisation programme of the country, and specifically hereby requests Gavi support for:

HPV quadrivalent, 1 dose(s) per vial, LIQUID routine introduction

Meningococcal A, 10 dose(s) per vial, LYOPHILISED preventive campaign

The Government of Kenya commits itself to developing national immunisation services on a sustainable basis

in accordance with the Comprehensive Multi-Year Plan presented with this document. The Government requests that the Gavi and its partners contribute financial and technical assistance to support immunisation of children as outlined in this application.

Table(s) **6.2.3, 6.2.4** in the Routine New Vaccines Support of this application shows the amount of support in either supply or cash that is required from the Gavi.Table(s) **6.2.3, 6.2.4** of this application shows the Government financial commitment for the procurement of this new vaccine (NVS support only).

Table(s) **7.2.3** in the Preventive Campaign Support of this application shows the amount of support in either supply or cash that is required from the Gavi.

Following the regulations of the internal budgeting and financing cycles the Government will annually release its portion of the co-financing funds in the month of **June**.

The payment for the first year of co-financed support will be around **June 2018** for HPV quadrivalent, 1 dose(s) per vial, LIQUID.

Please note that this application will not be reviewed or recommended for approval by the Independent Review Committee (IRC) without the signatures of both the Minister of Health and Minister of Finance or their delegated authority. These signatures are attached as DOCUMENT NUMBER : 1 and 2 in Section 10. Attachments.

Minister of Health (or delegated authority)		**Minister of Finance (or delegated authority)**	
Name	Mr Julius KORIR, CBS	**Name**	Dr Kamau THUGGE, CBS
Date		**Date**	
Signature		**Signature**	

Proof of involvement of the Ministry of Education will also be required for HPV Routine Support. The Ministry of Education will either have to be involved in the ICC process (preferred option) and, for countries choosing schools as a location for vaccinations, or choosing a school link strategy, the Minister of Education (or delegated authority) must provide its signature. The signature is attached as DOCUMENT NUMBER : 3 in Section 10. Attachments.

Minister of Education (or delegated authority)	
Name	Dr Richard KIPSANG, CBS
Date	
Signature	

This report has been compiled by (these persons may be contacted in case the Gavi Secretariat has queries on this document):

Full name	Position	Telephone	Email
Dr Collins TABU	Head NVIP	+254727771101	ctabu.epi@gmail.com, head.epi@gmail.com

4.1.2. National Coordination Forum (Interagency Coordinating Committees (ICCs), Health Sector Coordinating Committees (HSCCs), and other equivalent bodies)

To be eligible for support, Gavi asks countries to ensure a *basic* functionality of their Coordination Forum (ICC/HSCC or equivalent body). Countries can demonstrate this by adhering to the requirements listed in section 5.2 of the General Guidelines. The information in this section and a set of documents submitted along with this application will help the Independent Review Committee (IRC) to assess adherence.

Profile of the Coordination Forum

Name of the Forum	Child Health Inter-agency Coordinating Committee
Organisational structure (e.g., sub-committee, stand-alone)	Committee

The Terms of Reference for the Coordination Forum is attached as DOCUMENT NUMBER : 4. The Terms of Reference should include all sections outlined in Section 5.2 of the General Guidelines..

Please describe the role of the Coordination Forum and stakeholders' participation (e.g. government, key donors, partners, key implementers, CSOs) in developing this proposal:

The National Immunization Technical Working Group is led by the EPI Manager and is accountable to the Child Health Interagency Coordination Committee (CH-ICC) which is chaired by the Director of Medical Services or his delegated officer. Membership to the TWG consists of program leads from the government departments, partner organizations and CSO supporting immunization program. The CH-ICC draws its membership from Government of Kenya, Development Partners, Implementing Partners and CSO.

The CH-ICC receives technical inputs from technical working groups that are set up with authority and approval by the ICC for particular topics and areas such as new vaccine introductions, proposals and applications, and campaigns. In September 2016, the ICC endorsed plans for HPV vaccine national introduction acknowledging the high cost associated with the school-based strategy. The immunization technical working group was tasked to look into ways this cost could be reduced, and to come up with strategies that could be used. The CH-ICC was in favor of a national roll-out rather than phased roll out. The ICC stressed the importance of collaboration with various stakeholders for the success of the exercise.

This proposal was developed by the immunization technical working group whose members included: National Vaccines and Immunization Program (NVIP), Reproductive and Maternal Health Services Unit, National Cancer Control Program, Ministry of Education and partners including WHO, UNICEF, CHAI, USAID-MCSP, and CSOs such as KANCO and Kenya Network of Cancer Organizations. The technical working group is constituted by members of NVIP from the various sub-committees as per thematic areas including training, advocacy communication and social mobilization, logistics, monitoring and evaluation.

Plans to introduce HPV vaccine were also shared with School Based Deworming Program and potential areas of collaboration were identified

The proposal has been shared with the Child Health ICC who gave their support for the application. The proposal to introduce HPV vaccine was also presented to the Kenya National Immunization Technical Advisory Group and recommended introduction of HPV vaccine.

4.1.3. Signature Table for the Coordination Forum (ICC/HSCC or equivalent body)

We the members of the ICC, HSCC, or equivalent committee *[1]* met on the **13/04/2017** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation which is attached. The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached as Document number 5. The signatures endorsing the proposal are attached as Document number 7 (please use the list for signatures in the section below).

Function	Title / Organisation	Name	Please sign below to indicate the attendance at the meeting where the proposal was endorsed	Please sign below to indicate the endorsement of the minutes where the proposal was discussed
Chair	Director of Medical Services	Dr Jackson KIOKO K., OGW		
Secretary	Head, Division of Family Health	Dr Mohammed SHEIKH		
Members	Head, National Vaccines and Immunization Program	Dr Collins TABU		
	Head, Neonatal Child and Adolescent Health Unit	Dr Warfa OSMAN		
	Director, MCSP	Gathari NDIRANGU		
	Country Director, Clinton Health Access Initiative	Gerald MACHARIA		
	KANCO	Jack NDEGWA		
	HENNET	JohnPaul OMOLLO		

	RMNCH/FP Specialist, USAID	Lilian MUTEA		
	IRCK	Patricia CHAMIA		
	Chief of Health, UNICEF	Rory NEFDT		
	WR, World Health Organization	Rudolf EGGERS		

By submitting the proposal we confirm that the quorum has been met. **Yes**

The minutes from the meeting endorsing the proposal and of the meetings of the past 12 months are attached are attached as DOCUMENT NUMBER : 6.

4.2. National Immunization Technical Advisory Group (NITAG)

Has a NITAG been established in the country ? **Yes**

We the members of the NITAG met on the **20/04/2017** to review this proposal. At that meeting we endorsed this proposal on the basis of the supporting documentation describing the decision-making process through which the recommendations were reached, attached as Document number 31.

4.2.1. The NITAG

Profile of the NITAG

Name of the NITAG	Kenya National Immunization Technical Advisory Group
Year of constitution of the current NITAG	2014
Organisational structure (e.g., sub-committee, stand-alone)	Independent
Frequency of meetings	Quarterly

Function	Title / Organisation	Name
Chair	Paediatrician/Kenya Paediatric Association - University of Nairobi	Prof. Fred WERE
Secretary	MOH NVIP/DSRU as secretariat	Collins TABU, Edwina ANYANGO, Samson THUO, Philip MUTHOKA
Members	Infectious Diseases - Kenya Medical Research Institute	Dr. AMUKOYE Evans
	Paediatrician/Researcher - University of Nairobi	Dr. Boniface OSANO
	Immunologist – University of Nairobi	Dr. Chris GONTIER
	Paediatrician/Kenya Paediatric Association - Private practice	Dr. David GITHANGA
	Medical/Public Health law – Private Practice	Dr. Kiama WANGAI
	Internal medicine - University of Nairobi	Dr. Marybeth MARITIM
	Epidemiologist - University of Nairobi	Dr. ONGORE Dismas
	Paediatrician - Private Practice	Dr. Zipporah GATHERU
	Microbiologist/researcher - Kenya Medical Research Institute	Mr. Julius TUEI

Major functions and responsibilities of the NITAG

The Kenya National Immunization Technical Advisory Group (KENITAG) serves as a scientific and technical advisory body to the Ministry of Health on matters relating to vaccines and immunization policy, within its overall terms of reference.

Terms of reference:

1. Conduct analyses of vaccine characteristics, vaccine-preventable disease epidemiology, and programmatic capacity to determine the optimal national policies on vaccines and immunization in accordance with the National Health Sector Strategic Plan(NHSSP), specifically:

   - Provide recommendations on the continuation or modification of existing policies.

- Advise on the introduction of vaccines currently not in use in Kenya and of potential relevance to public health.

1. Identify the need for further data for policymaking and Advise the government in the collection of these data.
2. Advise the national authorities in the monitoring and evaluation of the national immunization program and provide recommendations on the continuation or modification of existing programmatic activities.
3. Keep the national authorities and the immunization program updated on the latest scientific developments in the area of vaccines and vaccine-preventable diseases

In the absence of a NITAG, countries should clarify the role and functioning of the advisory group and describe plans to establish a NITAG. This document is attached as **(Document Number: 8)**

5. Immunisation Programme Data

5.1 Background information

Please complete the table below, using the most recent data from available sources. Please identify the source of the data, and the date and attach the source document, where possible. The following documents should be referred to and/or attached:

- Comprehensive Multi-Year Plan for Immunisation (cMYP) (or equivalent plan). Please attach as DOCUMENT NUMBER 9.
- New Vaccine Introduction Plan(s) / Plan of Action. Please attach as DOCUMENT NUMBER 12.
- New Vaccine Introduction Checklist, Activity List and Timeline. Please attach as DOCUMENT NUMBER 12.
- Effective Vaccine Management (EVM) assessment. Please attach as DOCUMENT NUMBER 20.
- Two most recent annual WHO/UNICEF Joint Reporting Forms (JRF) on Vaccine Preventable Diseases.
- Health Sector Strategy documents, budgetary documents, and other reports, surveys etc, as appropriate.
- In the case of Yellow Fever and Meningitis A mass preventive campaigns, the relevant risk assessments. Please attach as DOCUMENT NUMBER 24 and DOCUMENT NUMBER 25.

Please use the most recent data available and specify the source and date.

	Figure	Year	Source
Total population	45,367,322	2016	Kenya National Bureau of Statistics
Birth cohort	1,591,167	2016	Kenya National Bureau of Statistics
Infant mortality rate (per 1000)	39	2014	Kenya National Bureau of Statistics
Surviving infants*[1]*	1,514,775	2016	Kenya National Bureau of Statistics
GNI per capita (US$)	1,340	2015	World Bank
Total Health Expenditure (THE) as a percentage of GDP	3.7	2012	National Health Accounts
General government expenditure on health (GGHE) as % of General government expenditure	3.7	2016	Kenya Budget Estimates

[1] Surviving infants = Infants surviving the first 12 months of life

5.1.1 Lessons learned

Routine New Vaccines Support

If new or under-used vaccines have already been introduced in your country, please give details of the lessons learned from previous introduction(s) specifically for: storage capacity, protection from accidental freezing, staff training, cold chain, logistics, coverage and drop-out rates, wastage rate, etc., and suggest action points or actions taken to address them. Please refer to previous Post Introduction Evaluations (PIE), if applicable. If they are included in the Introduction Plan, please cite the section only. If this information is already included in NVIP/POA, please reference the document and in which section/page this information can be found.

Lessons Learned	Action Points

Please refer to the New Vaccines Introductions Plan	

Preventive campaign support

If campaigns with Meningococcal A, 10 dose(s) per vial, LYOPHILISED vaccines have already been conducted in your country, please give details of the lessons learned, specifically for: storage capacity, protection from additional freezing, staff training, cold chain, logistics, coverage, wastage rate, etc., and suggest action points to address them in future campaigns. If they are included in the Introduction Plan or Plan of Action, please cite the section only. If this information is already included in NVIP/POA, please reference the document and in which section/page this information can be found.

Lessons Learned	Action Points
Please refer to the Men A preventive vaccination Campaign Plan of Action	

5.1.2 Health planning and budgeting

Please provide information on the planning and budgeting cycle in your country

The Kenya Vision 2030 is a long term development plan that aims to transform Kenya into a newly industrialized middle income economy providing high quality life to all its citizens by 2030. The long term economic planning perspective is guided by Vision 2030, with medium term plans (MTPs) and short term forecasts (annual budgets). Planning and Budgeting in Kenya takes place within the framework of the Medium Term Expenditure Framework (MTEF) which is a three year rolling budget and linked into policy making and planning process. The MTEF is also tied into Kenya's "Vision 2030" as well as the SDG's and the respective ministries core objectives and mandates. Kenya's budgeting cycle begins in July of each year and ends in June of the subsequent year.

The Constitution of Kenya provides the broad principles of public finance, with the Public Finance Management Act, 2012 providing guidelines for budgeting for both national and county governments. The National Treasury prepares the national budget while county treasuries

The MTEF budget process consists of three major parts

- Macroplanning (August-September)
- Analyzing sectoral priorities (October- January)
- Preparation and approval of budgets (February-June)

At the national level, the Cabinet Secretary of the National treasury issues a circular guiding the budgeting process before August 30th. This process begins with a proposed sector distribution in the Budget Review and Outlook Paper (BROP), normally released in October or November. That proposed sector distribution is finalized in the Budget Policy Statement (BPS), approved by Parliament in March. After this, the budget estimates are finalized and tabled in April with ministry, program, and sub-program details. Between the BROP and the BPS, the process of reviewing and adjusting sector proposals is meant to be carried out by what are known as Sector Working Groups (SWGs). SWGs are meant to facilitate government coordination around the budget, so that the main departments and agencies within each sector negotiate over priorities. The national budgeting process involves:

- Preparation of an integrated development plan
- Prioritization
- Developing a budget policy statement that estimates revenues and expenditures
- Approval of the budget policy statement
- Adoption of estimates by National Assembly
- Enacting the Appropriation Bill (by June 30)
- Implementing the budget
- Accounting and evaluating all budgeted items
- Public participation

At the county level, the management of budget process for each county is the responsibility of the County Executive Committee Member in charge of Finance (CECMF). The CECMF issues a circular guiding the budget making process before August 30 every year. The County Budget and Economic Forum sets off the budgeting process by preparing the County Development Plan, the County Fiscal Strategy Paper and County Budget Review and Outlook Paper (CBROP). The county budget making process involves:

- Preparation of an integrated County Development Plan
- Prioritization
- Estimating revenues and expenditures
- Approval of the County Fiscal Strategy Paper that contains the strategic priorities for the county, estimates, revenue, expenditure and deficit for the subsequent financial year
- Preparing and submitting budget estimates to county assembly
- Adoption of estimates by county assembly
- Enacting county appropriation law
- Implementing budget
- Accounting for and evaluating budgeted items
- Public participation

Please indicate the name and date of the relevant planning document for health

The Kenya Health Sector Strategic and Investment Plan (2014-2018)

Is the cMYP (or updated Multi-Year Plan) aligned with the proposal document (timing, content, etc.)

The cMYP (2015-2019) projected the national roll-out of HPV vaccine in 2017. Bearing in mind the need for resource mobilization and other preparatory activities, introduction is now planned for 2018

Please indicate the national planning budgeting cycle for health

The planning framework for the Ministry of Health identifies the place of the Ministry annual work plans in the overall planning framework

The Ministry of Health prepares annual work plans that

- Are informed by key sector policy and strategic documents (KHSSP, Kenya Health Policy)
- Are based on estimates of budget allocations to the sector at national level provided in the Medium-Term Expenditure Framework
- Define the priority activities of the Ministry based on available government and donor funds.
- Are a necessary step in the development of individual, departmental and divisional performance contracts

All health programmes are captured in the annual work plan and submitted to the Ministry of Health where they are aggregated before being submitted to the Ministry of Finance for consolidation into the National Budget. Disease programme plans are prepared by the respective National Programmes in the Ministry of Health and submitted to Ministry of Finance.

Please indicate the national planning cycle for immunisation

The comprehensive multi-year plan is developed every five years and annual immunization operational plans are developed from the cMYP.

5.1.3 Coverage and equity

Please describe any health systems bottlenecks or barriers to access, utilisation and delivery of immunisation services at district level (or equivalent), for example geographic, socio-economic and/or gender-related barriers. Please indicated if there are specific populations of concern. If available, please provide subnational coverage and equity data highlighting geographic, socio-economic, gender-related, or other barriers and any other relevant categories of vulnerable or high-risk populations.

The Kenya Demographic Health Survey of 2014 estimated fully immunized child at 79% with high coverage of BCG (97%), OPV 3 (90%), Pentavalent 3 (90%). The immunization coverage in the Kenya Demographic Health Survey of 2014 was higher for most antigens compared to administrative data and the program has planned for data quality improvement measures for the administrative data to close difference in the two data sets and provide better accuracy in routine monitoring results.

In 2016, an estimated 1,591,167 children were born of whom 1,514,775 survived. Of the surviving infants, 78% received three doses of Penta vaccine, (Draft JRF 2016).

In 2016 the national Penta 1 – Penta 3 dropout rate was 6%, which is less than the target of point of 10% and a sign of good utilization. The routine administrative coverage of Measles second dose was however low with only 32% of the eligible children receiving the vaccine. The country conducted a measles rubella vaccination campaign in May 2016 targeting children aged 9 months-14 years with a post-campaign coverage survey revealing a coverage of 95%.

A two-year HPV vaccine demonstration project conducted in one county between 2013 and early 2015 achieved coverage of 96% and 86% in the first and second year respectively.

An estimated 330,000 children are under-vaccinated (DPT3) in 2016 in Kenya half of them in the poorest performing 12 counties. Access to immunization services, as measured by Penta 1 coverage, was 80%. Low coverage (37%) was reported in Mandera county. The last KDHS (2014) did not identify significant differences in access to immunization services by gender.

Possible reasons for poor performance in parts of the country include:

i) Geographical – The twelve counties with the highest number of unimmunized children for Pentavalent 3 are Mandera, Kakamega, Kisii, Bungoma, Trans-Nzoia, Narok, Nandi, Wajir, Kitui, Homa Bay, Bomet, Meru(Draft JRF 2016). Ten of these counties are among the 16 Gavi HSS focus counties while two of them are targeted through the 2017 Gavi TCA and other local partnerships. Mandera county which borders Somalia which has suffered several years of insecurity and this may explain poor performance. The government continues to address security issues in the northern part of the country especially areas bordering Somalia.

The national drop-out rate for Pentavalent (Penta 1 vs Penta 3) is 6% which reflects good utilization. However, seven counties have drop-out rates equal to or greater than 10%: Turkana, West Pokot, Marsabit, Isiolo, Samburu, Garissa and Tana River. These are vast counties with long distances between facilities, poor road and infrastructure networks. In addition, the populations in these counties lead a nomadic life which is characterized by migration. All these counties will receive support through the Gavi HSS grant with six receiving an EPI utility vehicle from the Gavi HSS and three being supported for outreaches.

ii) Socio-economic factors – Analysis of health DHS 2014 reports lowest vaccination coverage amongst households in the lowest wealth quintile, with no education and in rural areas. Trend analysis from 1989 to 2014 confirms that access to education and wealth are the two major determinants for full immunization. Gender does not seem to be a significant factor in access to immunization services (KDHS 2014)

Kenya boasts high primary school enrolment rates of 88.4%. Since majority of the target population is school going involvement of the education sector in planning and implementation is key. The gender parity based on absolute enrolment was 0.96 in 2014 (girls/boys) which shows that girls are accessing school as much as boys. Messaging will therefore be tailored to reach both in school and out of school girls. Health education shall also involve boys.The program will review social mapping to identify gender equity gaps and will identify oppurtunities for strengthening during the microplanning process. The program will focus on hard to reach areas such as nomadic populations, geographically isolated communities, border communities and refugees.

Please explain how the proposed NVS support (activities and budget) will be used to improve coverage and equity of routine immunisation with reference to specifically identified health systems bottlenecks and/or specific populations of concern. For countries that will be receiving Gavi HSS and/or CCEOP funding concurrently with NVS funds, please also highlight how NVS funds will support/complement/leverage specific activities or investments included in those other grants.

With NVS support, the following activities will be carried out

- Planning and Coordination including microplanning
- Advocacy, communication and social mobilization including development of a communication plan
- Service delivery including capacity building and outreach
- Vaccine and logistics supply management
- Waste management
- Monitoring and evaluation
- Microplanning will explicitly identify the target population (location and numbers), how they will be reached and resources required. Microplans will be developed up to health facility level, with the health facility identifying strategies to reach the target population. For example, those in hard-to-reach areas can be reached through outreach services (community and school). The routine immunization system will be strengthened through development and implementation of comprehensive micro-plans. Health workers will be familiarized with the microplanning process, a process that can identifies where

unimmunized children are and how they can be reached
- Demand generation for immunization will be done through advocacy, communication and social mobilization. This will involve high profile launches, radio and television messaging. Media briefs and interviews will be an opportunity to interact with the general public and convey immunization messages.
- Training of health workers will include updates on EPI and general capacity building of health workers skills
- The proposed supportive supervision and Post Introduction Evaluation will evaluate most of the aspects of the immunization program and implementation of recommendations should improve other immunization indicators as well
- Lessons learnt during implementation and planning will be applied during other new vaccine introductions
- Kenya successfully applied for the Gavi HSS funding in which 17 counties are targeted
    - Funds for outreach are available through the Gavi HSS for 17 counties. Outreach will be used to supplement the facility based strategy especially in hard to reach areas.
    - The HSS provides for demand generation through airing of media messages. HPV vaccination will be factored during the development of these messages
    - Advocacy to county leadership to provide financing for immunization will be conducted under HSS. Such funds can be used to enhance immunization activities such as advocacy, outreach, capacity building.
    - The HSS will also provide vehicles for 14 counties, boats for 2 counties and a refrigerated truck. These will be used to transport EPI vaccines including the HPV vaccine. These will be allocated to specific counties that are vast and hard-to-reach
    - Training and CME activities funded under HSS will be used to update health workers on the New Vaccines
    - Immunization performance review meetings supported under the HSS will be an opportunity to report and deliberate on the coverage of the new vaccines.

Kenya also applied for the Gavi CCEOP which will address cold chain capacity gaps across the country. Once awarded, the CCEOP will allow health care facilities that were previously not offering immunization services due to lack of equipment to do so, thereby increasing access HPV and other routine vaccines. The CCEOP will also mitigate the potential strain HPV vaccine may have on the existing cold chain infrastructure.

Please describe what national surveys take place routinely in country to assess gender and equity related barriers. Highlight whether this application includes any activities to assess gender and equity related barriers.

The Kenya Demographic Health Survey conducted every five years assess various health equity indicators. The most recent KDHS (2014) did not identify significant differences in access to immunization services by gender.

Please indicate if sex disaggregated data is collected and used in immunisation routine reporting systems.

No sex disaggregated data is not collected routinely for immunization services. However, sex disaggregated data is collected from cross-sectional surveys like DHS.

Is the country currently in a situation of fragility (e.g. insecurity, conflict, post-conflict, refugees/and or displaced persons and recent, current or potential environmental disaster, such as flooding, earthquake or drought or others)? If Yes, please describe how these issues may impact your immunisation programme, planning for introduction of routine vaccines or campaigns and financing of these activities.

Kenya is not a security fragile country, however some areas in the north of the country (bordering Somalia) have experienced insecurity. This has resulted in low coverage as health workers are reluctant to work in these areas. Access to these areas is also poor. The government is continuously addressing security issues in these areas. The country has also a significant population living in the refugee camps. HPV vaccine will be provided through the routine immunization system in facilities at the refugee camps or through outreach.

5.1.4 Data quality

To support country efforts to strengthen the availability, quality and use of vaccination coverage data for strengthened programme management, Gavi requires that countries applying for all types of Gavi support to

undertake routine monitoring of vaccination coverage data through an annual desk review; conduct periodic (once every five years or more frequently where appropriate) in-depth assessments of routine administrative vaccination coverage data; conduct periodic (at least once every five years) nationally representative vaccination coverage surveys; and develop and monitor plans for improving vaccination coverage data quality as a part of their own core work plans.

5.1.5 HPV specific facts

Countries applying for HPV that have already conducted a demonstration or pilot programme, should include details on specific lessons learned for HPV vaccine delivery.

Key programmatic areas	Lessons Learned	How these areas have been addressed in a National Plan
Preparation & planning	Inadequate micro planning process in Kenya with the changes in administrative units lead to changes in targets in the initial HPV implementation plan, and resulted in a challenging introduction of HPV vaccines. Timely vaccine supply is a critical and important issue for the implementation of HPV demonstration project, this will help in adherence to the planned schedule and schools programmes; in additional extra distribution costs can be incurred from an erratic supply;	Adequate microplanning will be conducted well in advance of the exercise in conjunction with relevant stakeholders at national, county and sub county levels. The microplanning will be done nationally and will rely heavily on the Kenya National Bureau of Statistics (KNBS) for the official population. This will ensure that all populations are addressed and no population is missed in the planning process. Ministry of Education is a key stakeholder in the micro-planning process and a member of the Immunization Technical Working Group.
Communication & social mobilization	Appropriate advocacy and social mobilization using the cervical cancer prevention platform can be used as a mechanism for advocating for increased Government contribution and local resources mobilization for HPV vaccination	The role of HPV vaccine in prevention of cervical cancer needs to be communicated to various stakeholders and engage cervical cancer survivors as ambassadors for HPV vaccine The program will collaborate with other programs targeting the same age group to conduct sensitization for HPV vaccine, for example School Based Deworming Program.
Delivery strategies	School based strategy yielded high coverage but was expensive. The integration with the Ministry of Education was critical in achieving a high coverage and are a critical partner in identifying the target population.	The government has elected its primary strategy to be a facility based strategy, complemented by other strategies such as school outreach. The Ministry of education is critical partner in this approach and will identifying un-immunized girls in schools and will refer them to facilities.
Coverage	It is feasible to attain a high coverage and high acceptability. The coverage achieved in year 1 of the pilot 96% and in the second year it was 86%.	The Facility based strategy complemented by other strategies and intensive advocacy efforts can achieve a high coverage.
Reporting & monitoring	There is need to update data capture and support supervision tools.	The tools required to record vaccination will be updated to include HPV vaccines. These tools will include the HPV register, Tally sheets and the summary sheets. A vaccination card will be issued to the targetted girls and the status on the vaccination card will be confirmed in schools during the opening ceremonies.
Sustainability	Government of Kenya mobilized resources to vaccinate additional girls than the application to Gavi had asked for during the demonstration project	The role of HPV vaccine in prevention of cervical cancer needs to be communicated to various stakeholders especially at county level in order to advocate for increased financing for immunization operational costs. Appropriate advocacy is likely to yield domestically mobilized resources to sustain the national program

For each district in which the demonstration/ pilot programme was implemented, please complete the following:

District Information	
Name of the district	Kitui County
Size of target population of the district	42,871
Describe how the district is divided into rural and urban areas:	Rural inhabitants (72%)
Delivery strategy(ies) used (e.g. school based, health centre based, campaign)	School based strategy (in school girls) and community outreach (out of school girls). The coverage achieved in year 1 of the pilot 96% and in the second year it was 86%.

5.2. Baseline and Annual Targets for Routine Vaccines

For HPV, Gavi supports the vaccination of girls aged 9-14 years, based on the following cohorts:

- Routine cohort – countries are required to identify a single year cohort of girls to be immunised on a routine basis. (e.g. 9 years old)
- Additional multi-age cohort – in the first year of introduction (or initial year of each phase, if country choose phased introduction), countries also have the option to immunise additional girls within the recommended age groups (e.g. 10-14 years), that are older than the routine cohort.

Note: Countries may choose proxy age of girls based on a school grade (e.g. grade 5 corresponds to approximately 10 year olds). However, grades usually have a range of different aged girls so it is important to keep in mind that girls under 9 years should not be vaccinated, and doses for girls older than 14 years are not provided by Gavi.

Please specify the chosen age for the routine cohort HPV vaccination: e.g. 9 years

10 years

If relevant, please specify the chosen age range for the additional multi-age cohort in the year of introduction: e.g. 10, 11, 12, 13, 14 years
From :

11 years

To :

14 years

Will a phased introduction approach be adopted?

No

If a phased approach will be adopted, please provide an explanation for this approach.

Please refer to cMYP pages to assist in filling-in this section. For HPV, please also refer to Annex 3 of the HPV Guidelines.
The Base year information should be completed for the year in which the application is being completed.

Table 5.2: Baseline NVS routine figures

Number	Base Year	Baseline and Targets
	2016	2018
Total births	1,591,167	1,689,559
Total infants' deaths	76,392	84,478
Total surviving infants	1,514,775	1,605,081
Total pregnant women	1,591,167	1,689,559
Target population (routine cohort) vaccinated with OPV3*[1]*	1,155,116	1,444,573
OPV3 coverage*[2]*	76 %	90 %
Target population (routine cohort) vaccinated with DTP1*[1]*	1,269,542	1,524,827
Target population (routine cohort) vaccinated with DTP3*[1]*	1,187,290	1,444,573
DTP3 coverage*[2]*	78 %	90 %
Wastage*[3]* rate in base-year and planned thereafter (%)	10	10

for DTP		
Wastage*[3]* factor in base-year and planned thereafter for DTP	1.11	1.11
Routine Cohort		
Number of girls in the routine cohort		766,207
Target population (routine cohort) vaccinated with 1st dose of HPV	0	612,966
Target population (routine cohort) vaccinated with 2nd dose of HPV	0	612,966
HPV quadrivalent coverage 1st dose	0 %	80 %
HPV quadrivalent coverage 2nd dose	0 %	80 %
Additional multi-age cohort		
Number of girls in the additional multi-age cohort	2,324,192	2,467,913
Target population (additional multi-age cohort) vaccinated with 1st dose of HPV quadrivalent	1,859,354	1,974,330
Target population (additional multi-age cohort) vaccinated with 2nd dose of HPV	1,859,354	1,974,330
HPV quadrivalent coverage*[2]*	80%	80%
HPV quadrivalent coverage 2nd dose	80%	80%
First Presentation: HPV quadrivalent, 1 dose(s) per vial, LIQUID ROUTINE COHORT + ADDITIONAL MULTI_AGE COHORT		
Wastage*[3]* rate in base-year and planned thereafter (%)	5	5
Wastage*[3]* factor in base-year and planned thereafter (%)	1.05	1.05
Maximum wastage rate value for HPV quadrivalent, 1 dose(s) per vial, LIQUID	5 %	5 %
Second Presentation: HPV bivalent, 2 dose(s) per vial, LIQUID ROUTINE COHORT + ADDITIONAL MULTI_AGE COHORT		
Wastage*[3]* rate in base-year and planned thereafter (%)	5	5
Wastage*[3]* factor in base-year and planned thereafter (%)	1.05	1.05
Maximum wastage rate value for HPV bivalent, 2 dose(s) per vial, LIQUID	10 %	10 %
Target population (routine cohort) vaccinated with 1st dose of MCV	1,130,812	1,444,573
MCV coverage*[2]*	75 %	90 %
Annual DTP Drop out rate [(DTP1 – DTP3) / DTP1] x 100	6 %	5 %

[1] Indicate total number of children vaccinated with either DTP alone or

combined

[2] Number of infants vaccinated out of total surviving infants

[3] The formula to calculate a vaccine wastage rate (in percentage): [(A - B) / A] x 100. Whereby: A = the number of doses distributed for use according to the supply records with correction for stock balance at the end of the supply period; B = the number of vaccinations with the same vaccine in the same period.

5.2.1 Description of routine and additional multi-age cohorts

Provide the percentage of primary school enrolment

88.4 %

Provide the percentage of secondary school enrolment

47.8 %

Provide the average age of entry for secondary school

14 years

Please provide a source for the enrolment data (e.g., national statistics office, MOE, recent census, school registers, etc.)

Ministry of Education

Please provide a source for the enrolment data (e.g., national statistics office, MOE, recent census, school registers, etc.)

Ministry of Education

5.2.2 HPV specific targets

Girls to be vaccinated with HPV should be within the WHO-recommended target population of 9-14 years old girls

Please specify the source of data that was used to estimate the number of girls in the routine and, if relevant, additional multi-age cohorts and reported in the above table under "Target population (routine cohort) vaccinated with HPV" and "Target population (additional multi-age cohort) vaccinated with HPV"

Kenya National Bureau of Statistics

5.3. Targets for Preventive Campaign(s)

Please refer to cMYP pages to assist in filling-in this section. For HPV, please also refer to Annex 3 of the HPV Guidelines.
The Base year information should be completed for the year in which the application is being completed.

5.3.1 Targets (Meningococcal A campaign)

Mini catch-up campaigns will be introduced at the same time as routine EPI. Gavi will support one-time mini catch-up campaigns with Meningococcal A conjugate vaccine targeting cohorts born between the initial mass campaign and introduction of routine infant vaccination in all 26 endemic countries in the African meningitis belt. The exact age range will depend on the specific country epidemiology and situation, although the target number to be reached should be included in table 5.3.1)

Cohort for Meningococcal A via mass preventative campaigns is population 1-29 years old

Table 5.3.1 Baseline NVS campaign figures for Meningococcal A

Number	Targets: preventative mass campaigns
	2018
Total target population	3,116,626
Wastage rate (%) for Meningococcal A (campaign)	10
Maximum wastage rate value for Meningococcal A (campaign)	10 %

Number	Targets: mini catch-up campaigns
	2018
Total target population	0
Wastage rate (%) for Meningococcal A (campaign)	0
Maximum wastage rate value for Meningococcal A (campaign)	10 %

5.4. Targets for One time mini-catchup campaign(s)

No One time mini-catchup campaign this year

6. New and Under-Used Vaccines (NVS Routine vaccines)

6.1. Assessment of burden of relevant diseases (if available)

If already included in detail in the Introduction Plan or Plan of Action, please cite the section only.

Disease	Title of the assessment	Date	Results

6.1.1 HPV burden specific information

Has the country undertaken an assessment of the burden of cervical cancer? If so, describe the burden, and when and how the assessment was done. If not, countries may report on Globocan data (available on the WHO HPV information Centre website at http://www.who.int/hpvcentre/en).

The country is yet to undertake an assessment on the burden of cervical cancer. However, according to Globocan 2012, cervical cancer is the most common cancer among women in Kenya, with about 4,802 new cases being diagnosed annually in Kenya (estimations for 2012). There are about 2451 cervical cancer deaths annually. It is estimated that at least 13.4 million women are at risk of cervical cancer. The cumulative risk (%) at 75 years old for cervical cancer is approximately 2.5%.

Describe the existing cervical cancer prevention and control activities.

According to the Nairobi Cancer Registry at KEMRI, about 80% of reported cases of cancer are diagnosed at advanced stages, when very little can be achieved in terms of curative treatment. This is largely due to the low awareness of cancer signs and symptoms, inadequate screening services, inadequate diagnostic facilities and poorly structured referral facilities. The country has few cancer specialists who are concentrated in a few health facilities in Nairobi. This makes it difficult for a great majority of the population to access cancer treatment services resulting in long waiting times causing some previously curable tumors to progress to incurable stages.

The country developed the National Cancer Control Strategy (2011-2016) as a response by the Ministry of Health and stakeholders to the urgent need to prioritize cancer prevention and control in Kenya. It is recognized that the effects of the disease can be significantly reduced if effective measures are put in place to control risk factors, detect cases early and offer good care to those with the disease. The strategy aims to reduce the number of people who develop and die of cancer. It also aims to ensure a better quality of life for those living with the disease. Kenya also developed national cancer treatment guidelines that further describe treatment protocols for various forms of cancer including cervical cancer. The treatment guidelines outline services that need to be available at various levels of the health care system from the community level, the primary care service level (Dispensaries and Health Centres), the County Referral service level up to the National referral service level. The guidelines recognize that currently comprehensive cancer treatment facilities are limited to Kenyatta National Hospital (public sector) with services being offered to a limited degree at Moi Teaching and Referral Hospital, all Level Five Hospitals in the public sector

The strategy and guidelines identify the following key areas for prevention and control of cervical cancer:

- Primary prevention through vaccination with HPV vaccine
- Early detection through screening: Visual Inspection with Acetic Acid (VIA), Visual Inspection with Lugol’s Iodine (VILI)
- Diagnosis and treatment of cancer through improving accessibility to treatment
- Pain relief and palliative care
- Cancer surveillance and research through establishment of regional cancer registries.

- The country is currently updating the National Cancer Control Strategy

Has the country developed a strategy for establishing or strengthening a national comprehensive approach to cervical cancer prevention and control? **Yes**

If Yes, please attach and refer to section 10. Attachments. (Document N°**15,16**)

If No, are there plans for the country to develop such a roadmap or strategy in the future? Please describe- when, who will be leading the development of the plan, and which agencies will be involved.

6.1.2 Description of province/ region profile

Countries are required to attach a description of the profile for each province/ region, using the template provided by Gavi

Please attach the relevant documents "HPV Region/ Province profile " template provided by Gavi and attach as a mandatory document in the Attachment section. Document number **16**)

6.1.3 Delivery strategies for HPV vaccine

Please provide information on each of the following **delivery strategies** that will be:

- Using outreach to schools as a location for vaccinations
- Using health facilities as a location for vaccinations
- Using community outreach as locations for vaccinations
- Campaign

Using schools as a location for vaccinations

Please describe why this delivery strategy has been chosen for the selection region/ district(s). Will this delivery strategy be used for every year? If so, please describe how this strategy will be financed in future years.

This strategy is not the main strategy but will be used to complement the facility based strategy. Vaccination times will be arranged between health facility and the school leadership. The County Governments will carry out school outreach programs from their facilities and a special focus will be made for reaching the distant schools and the hard-to-reach schools. All components of the HPV vaccination will be provided through this approach. This strategy will be used every year with acceleration in the first year in order to reach the multi-cohort.

Please specify whether girls will be vaccinated by selection of a specific age or a specific school grade

Girls will be vaccinated according to age. The selected age is 10-year-old girls for the routine cohort and the additional 11-14-year-old girls for the multi age cohort.

Please complete table 6.1.3a vaccination by specific age or table 6.1.3b by specific school grade, depending on above choice

Table 6.1.3 a: Vaccination by specific age

Routine Cohort	
Specific age chosen	10 years
Target population of girls in chosen age	766207
Girls of chosen age enrolled in schools	

Aditional multi-age cohort	
Specific age-range chosen	Start 11 years End 14 years
Target population of girls in chosen age	2467913
Girls of chosen age range enrolled in schools	

Table 6.1.3 b: Vaccination by specific school grade

Routine Cohort		
School grade	**Average age of girls on school grade**	**Number of girls in grade**
	10 years	

Aditional multi-age cohort		
School grade	**Average age of girls on school grade**	**Average age of girls on school grade**
	11 years	
	12 years	
	13 years	

If you are vaccinating by grade, provide information on how you will ensure girls under 9 or over 14-years will not be vaccinated

Please describe when vaccinations will be scheduled (school year, holidays, examinations), where vaccinations will be administered, who will do vaccinations, how will the vaccine logistics be assured when using schools as a location for vaccination.

Vaccinations will be scheduled during the school year with health facility staff conducting outreach to the school.A preliminary analysis of the distances between schools and public facilities using GPS coordinates indicates that nationally 79% of schools are less than 5 kilometers from public health facilities and this varies from county to county. This strategy is complementary to the primary strategy and will be employed alongside the primary one. Health facility staff will liaise with school administration on the timing of vaccination. Health facility staff will then conduct an immunization outreach at the school. This means that a temporary immunization post will be created at a suitable location within the school

For those schools that may have school nurses, the nurse may pick vaccines and recording tools from health facility and conduct vaccination if facilitated by the school

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

Since the main vaccination is fixed post at the health facility,no additional personnel be hired for the vaccination of multi-age cohort. We will use the existing human resource of MOH.

Please describe the strategy to capture girls who may miss the initial vaccination session or any of the remaining doses

The vaccine will be available all year round in the facility, in addition defaulter tracing that will be done to capture those who have not come for second dose. In addition, the routine immunization system of defaulter tracing will be employed to identify those who miss the second dose. Additionally, outreaches will be carried out in schools to reach most of the girls.

Will the vaccination strategy need to be adapted for at private or religious schools? If so, please elaborate.

The strategy will be the same for all schools. However, different channels of communication and strategies will be used to reach the different schools. Potential non-acceptance will be will be addressed through advocacy with religious leaders and sensitization of parents and teachers

Using health facilities as a location for vaccination

Please describe why this approach has been chosen for the selection region/ district(s). Will this approach be used every year?

This approach has been chosen as the primary strategy. It is the least costly strategy and hence most sustainable and will be used from the time of introduction onwards.

HPV vaccine introduction will be fully integrated into the routine immunization system of the EPI program. This strategy was selected as it is less costly. HPV vaccine will be integrated into all the components of the EPI program such as immunization service delivery at facility, cold chain, advocacy communication, community linkage strategies and the vaccine supply system.

The service will be provided through several sections of the health facility such as the under 5 clinics, the mother and child clinics, the pediatric wards and the outpatient department. HPV vaccination will also be integrated into the reproductive health department messaging, advocacy and demand generation, clinics and youth friendly service points and integrated into the RH policy and cancer prevention strategy.

Linkages to schools will be possible through health facility arranging with schools to bring girls to the facility on a particular day, alongside the complementary approach of taking the vaccination to the schools on select days as agreed upon with the school administration.

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

No, addtional personnel will not be hired for the vaccination of multi-age cohort .

Please provide details of demand generation activities to encourage girls to come to the health facility?

Various advocacy and social communication activities will be carried out

- Public launches graced by prominent persons e.g. the first lady, women representatives at National, county and sub county levels.
- Key partnership with the Kenya Primary School Heads Association as a primary advocacy platform.
- Engagement of cervical cancer ambassadors: survivors
- Engagement of professional societies including KOGS and KPA
- Stakeholder consultative meetings at both National, County and Sub county levels
- Sensitization of school administration e.g. Parent Teacher Meetings
- Media engagement plans including media interviews, press briefings, airing of messages in mainstream and vernacular radio and television stations
- Involvement of Civil Society Organizations
- High level advocacy meetings
- Orientation meetings
- SMS alerts

Development and dissemination of information and promotional materials including posters and flyers among others

Please provide details on how the country plans to link with schools. Some examples of how schools can be leveraged to increase HPV vaccine uptake include facilitating sensitization and mobilization of parents/communities, identification/validation of the target population (i.e. use of school enrolment lists), and assisting with vaccination call/recall mechanisms. If the country does not plan to link with schools please provide a justification for this decision (i.e. low school enrolment).

Linkage to schools will be done through

- health facility arranging with schools to bring girls to the facility on a particular day
- sensitization of parents and teacher’s associations
- schools monitoring whether girls in target age group have been vaccinated
- mapping, linking and networking of schools and health facilities to enable school based vaccination on agreed days during the school term
- Using existing school health program interventions to carry out vaccinations and/or advocacy activities.

Describe if/how this delivery strategy will increase coverage, particularly amongst “hard to reach”/ vulnerable girls.

This strategy will be complemented with community and school outreach for the hard to reach areas. Both in and out of school girls will be able to access the facility

Describe what follow-up mechanism will be used to ensure girls receive their second dose.

All girls will receive an immunization card that will be the primary document for establishing immunization status and providing the date for the second dose.

As with routine immunization active defaulter tracing will be conducted using community health volunteers. In the Community Health strategy each community unit is linked to a health facility and girls identified through the Community health volunteers will be referred to facilities for vaccination. There will also be sensitization that will be conducted in schools for girls to return for second dose and the tracking of vaccination status of girls in school using their immunization card.

The guardians contacts will be obtained for reminders by facilities and other SMS reminders where possible.

Where vaccination is done through school linkage, the timing of vaccination will also be programmed within the school term so that where the 1st dose is delivered in Term 1, the second one is delivered in Term 3, which are 6 months apart and immunization status will be tracked through the immunization card provided to the girl.

Using community venues as locations for vaccinations

Please describe why this approach has been chosen for the selection region/ district(s).

This strategy is not the primary strategy but will complement the facility based strategy especially for hard to reach areas and nomadic groups.

Will this approach be used for every year? If so, please describe how this strategy will be financed in future years.

This approach will be used every year and in future shall be financed by the County Governents. County governments are responsible for immunization service delivery as therefore will provide financing for the outreaches.

Please describe how your community health care workers/ volunteers will be involved with this strategy

Community health workers will mobilize clients and also conduct defaulter tracing

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

No

Where in the community will the girls be vaccinated? E.g. schools, fixed outreach sites, streets, parks, malls, markets

Girls will be vaccinated in various outreach sites. The outreach site will vary from County to County taking into account the community characteristic. For example, Girls from nomadic populations with a low school enrollment will be targetted through mobile camps that offer other routine vaccinations. Other sites could include areas for social gatherings such as markets, churches, watering points and mosques depending on the context.

What interventions will be established to increase community based acceptance and increase community support?

The community will be sensitized on HPV vaccination through posters, leaflets, radio announcements, television announcements, television debates and interviews. Opinion leaders like chiefs and teachers, youth groups, religious leaders and youth social events will be mobilized and educated so as to increase community acceptance fo the vaccine.

Please provide details of demand generation activities e.g. awareness building and information dissemination via community or education sector and/or mass media, including through youth clubs and street theatre

While the traditional approach of radio, posters, leaflets and other IEC materials will be put to use, new approaches through social media will also be used. Such will involve the development of detailed FAQs on cervical cancer and details of where the vaccine can be accessed. Taking advantage of youth social events like sub-county and county level games and other social events to highlight the importance of the HPV vaccine will be heavily utilized.

Describe if/how this delivery strategy will increase coverage, particularly amongst “hard to reach”/ vulnerable girls?

This strategy favors hard-to-reach areas. Most can be reached through existing outreach programs, but market days, school term games, music festivals; all which are an integral and compulsory part of school life even in hard to reach areas will be intensively used as advocacy and service delivery platforms.

Describe what follow-up mechanism will be used to ensure girls receive their second dose.

The Community Health strategy is currently in place in 60% of the country and is increasing. Through this strategy the country will leverage on the community Health volunteers who will conduct defaulter tracing to seek out girls who missed the second dose, while school outreaches will be programmed to ensure the second dose is received inside the school year where applicable. School headteachers will be asked to maintain a register of vaccinated children in school where HPV vaccination status will be integrated into the school deworming programs.

Using campaigns to deliver HPV vaccines

Please describe why this approach has been chosen for the selection region/ district(s).

What type of campaign will be used for HPV vaccine delivery e.g. Child Health Days/ Weeks, Measles Rubella or tetanus containing vaccines, supplementary immunisation activities, health education activities? If the campaign is planned to be standalone, please explain why?

How will this campaign impact routine service delivery? For example, will health facility personnel be used for this campaign?

Will additional personnel need to be hired in order to vaccinate the introduction year multi-age cohorts? If so, how will this be financed?

What location(s) will be used to deliver vaccinations during the campaign?

Will this delivery strategy be used for every year? If so, please describe how this strategy will be financed in future years.

Describe if/how this delivery strategy will increase coverage, particularly amongst “hard to reach”/ vulnerable girls?

6.1.4 Social Mobilisation

Please complete the table below to provide details on the types of information and/ or materials that will be used/ disseminated, to which audience, by which mechanism and the frequency of each.

Types of information or materials	Audience receiving material	Method of delivery	Who delivers	Frequency & Timing
e.g., leaflet, poster, banner, handbook, radio	e.g., girls, parents, teachers, health workers, district officials, community	e.g., parent meetings, radio, info session at school, house visit, etc.	e.g., teachers, health workers, district official, etc.	e.g., daily, weekly, twice before programme starts; day of vaccination, two

announcement, etc.	groups, etc.			weeks before programme begins, etc.
1.Posters, Flyers 2. Banners, Tshirts, Sun visors 3.Vaccinator guide, Updated Immunization Schedule 4. Information on cervical cancer disease , Benefits of HPV vaccination in girls aged 10-14 years, Sensitization on benefits of regular screening for women,Risk communication 5. Sensitization materials (FAQs, briefs, how to dispel rumours and reports)	1.Girls, parents, teachers 2. Girls, parents, teachers, immunisation stakeholders at national and county level 3. Health workers 4. Girls, parents, teachers, community leaders, community groups and immunisation stakeholders at national and county level 5. Medical organizations like the Kenya obstetrician and Gynaecology society, Kenya paediatric association, media houses and health reporters.	1. Posting on school gates and walls at strategic points and distribution in strategic areas 2. During launches and stakeholder forums 3. Distribution during training sessions 4. a. Public Address System b. Advertisers Announcement in newspaper c. Supplement in newspaper d. Radio spots in mainstream radio channels and vernacular stations e. Interviews on TV stations and advertisement f.Social media: Facebook, You-tube and Twitter g. Road show h. Word of Mouth 5. Breakfast meeting with the relevant bodies	1. ACSM officers, community health volunteers 2.Health workers 3.Health workers 4. a. ACSM officers b. Minister of Health c. Director of Medical Services d. EPI manager e. Director of Medical Services f. Health Promotion Unit Head g. ACSM officers h.Community health volunteers 5. The sensitization materials will be developed and produced by the Ministry and the relevant body is expected to educate it's members and the media is expected to reach out to the public.	1. Two weeks before introduction 2.Daily for one week after the day of introduction 3. Daily, one week before exercise 4. a. Daily for 4 days after HPV vaccine introduction b.Daily for 2 days, after introduction of HPV vaccine c. Once, after introduction of HPV vaccine d. Daily for 5-7 days to start one week before introduction e. Daily for 5-7 days to start one week before introduction f.Daily one month before introduction of the vaccine g. Daily for 10 days, 3 days before vaccine introduction and for one week thereafter h.Daily for approximately 3 days per county 5. Before the program begins.

Please describe a crisis communication plan to response to rumors and misconceptions to HPV vaccination.

A crisis communication plan will be integrated within the communication strategy so as to address any AEFI, myths, misconception and resistance that may arise associated with either cervical cancer disease or the HPV vaccine. There is need to effectively communicate on cervical cancer disease prevention, with an emphasis on vaccination as one of the primary prevention strategies. The crisis communication plan will outline activities addressing

- risk communication on vaccine safety
- communicating with adolescents
- vaccine hesitancy from religious sects
- response to misconceptions and rumors in the media including social media

6.1.5 Adolescent health integration

Irrespective of the strategies, provide a description of existing health services and/or health education currently being provided to young adolescents (both girls and/or boys) within the 9-14 year old age group and indicate and potential synergy by integrating with HPV vaccination:

a. For health services (this can include: what health services are provided, to which age/sex group, whether it's mandatory or voluntary, regularly or ad-hoc, in school or out of school, who provides these (government, NGOs), how often, what is the uptake in the community, how is it perceived by the community.)

There exist various health interventions targeting adolescents and school going children including deworming, health education/health talks, Child Health Days (malezi bora), nutrition, adolescent sexual reproductive health and handwashing. These are provided through the Ministry of Health with support from partners. Most of these interventions are school based with teachers giving informed consent. Uptake of deworming in selected counties of implementation was found to be high in the same age group. Some facilities have youth friendly centres or offer youth friendly services where adolescents are given information on sexuality and other information as per need.

b. For health education (this can include: the topic, whether it is national, sub-national, in school or out of school, who provides the education, how often, is it in the school curriculum, are there NGOs providing these? How is it perceived by the community? Has there been an evaluation and if so, how was it evaluated and what were the findings?)

The school curriculum includes topics on the reproductive system in subjects such as Science and Biology. This is provided by teachers within the school curriculum. The new school curriculum will also include a thematic area on hygiene and nutrition

c. For improving adolescent immunization platform (this can include integration with: other vaccines provided to adolescents (e.g. measles-rubella, tetanus containing vaccines or Dengue), broader health education services)

Currently there are no routine vaccines administered to this age group.

6.1.6 CSO engagement

Please describe how and which CSOs will be included in the delivery of HPV vaccines e.g. demand generation activities, increase coverage of "hard to reach" girls.

Membership of the HPV vaccine introduction technical working group includes various CSO. The CSO are both those involved in immunization advocacy (KANCO and HENNET) and those involved in cancer advocacy (Kenya Network of Cancer Organizations). They will be involved in advocacy activities such as media breakfasts, stakeholder meetings. These CSOs have various chapters in the counties. In addition, KANCO is undertaking various demand generation activities within the HSS grant in focus counties. This will include demand generation for HPV vaccine. CSOs will identify HPV vaccine champions who will take part in advocacy and demand generation

6.1.7 Key stakeholder and technical partner roles and responsibilities

Please complete the Gavi provided template, to define the respective roles and responsibilities of all in-country stakeholders and technical partners.

Please attach the relevant documents and refer to section 10. Attachments. (Document N°**17**)

6.2. Requested vaccine (HPV quadrivalent, 1 dose(s) per vial, LIQUID)

As reported in the cMYP, the country plans to introduce HPV quadrivalent, using HPV quadrivalent, 1 dose(s) per vial, LIQUID.

When is the country planning to introduce this vaccine? **January 2018**

Please note that, due to a variety of factors, the launch date may vary compared to the date stipulated in the application. Gavi will work closely with countries and their partners to address these issues.

Please summarise the cold chain capacity (at central and other levels) and readiness to accommodate new vaccines, taking into consideration training, cold chain equipment and other logistical requirements. If cold chain expansion is required, state how it will be financed, and when it will be in place. The Independent Review Committee requires assurance that the cold chain is ready or will be ready for the routine introduction of the new vaccine, and evidence/plans need to be provided. All proposals that include Gavi- financing for cold chain equipment intended for vaccine storage shall need to procure equipment pre-qualified by WHO under their Performance Quality and Safety (PQS) program. The purchase of non-PQS equipment will only be considered on an exceptional basis, with justification and advance agreement from Gavi.

Kenya commissioned a new National Vaccine depot in 2014 through support from JICA with a total of 8 cold rooms with net capacity of 101M³ for positive temperature cold storage and 2 freezer rooms with net capacity for negative temperature cold storage of 14 M³. The objective of this was to build the capacity of the Country for new vaccine introduction through the decade with a quarterly vaccine delivery schedule to the regional vaccine stores.

The central vaccine store is located in Kitengela. There are 9 regional stores from where sub-county stores

collect vaccines: Nairobi, Mombasa, Kisumu, Nakuru, Eldoret, Garissa, Meru, Kakamega and Nyeri. There are 288 sub county vaccine stores which serve over 6911 facilities.

There have since been significant improvements in the cold chain capacity at the Facility and Sub County level since the last EVM assessment through investments by KFW, county government and partners. The country is due for an EVM Assessment, scheduled later this year. Following updating of the cold chain inventory in 2016, the country plans to cover any cold chain equipment gaps through the cold chain equipment optimization platform (CCEOP), expected early in 2018.

The country aims at procuring the preparation of the Quadrivalent vaccine that occupies the least volume and this is currently is estimated at 15cm3 per dose. Based on this and on the cold chain inventory conducted in 2016 the cold chain capacity analysis found that the central vaccine stores and the 9 regional depots had sufficient capacity to hold the HPV vaccine for the multi-age cohort.

Overall, total cold chain capacity at sub-county level is sufficient to hold HPV vaccines for the multi-age cohort. However, there exist inequities in cold chain capacity distribution among and within counties. Analysis of cold chain capacity at sub national level indicates that with a monthly supply cycle, more than 80% have sufficient capacity to accommodate the multi-cohort quantity of HPV vaccine and all the other routine vaccines. The implementation of CCEOP, review of the delivery cycles and redistribution of cold chain equipment will be able to bridge this gaps

6.2.1. Vaccine Prices

Vaccine	Presentation	2017	2018	2019
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	4.500	4.500	4.500

6.2.2. Co-financing information

The co-financing requirement applies to vaccines for the **routine cohort** (i.e. the cohort that will be routinely vaccinated on an annual basis for the routine immunisation programme). However, Gavi will fully finance vaccines for the **additional multi-age cohort** during the introduction year.

If you would like to co-finance an amount higher than the minimum, please provide information in Your co-financing row.

Country group	Preparatory transition phase

	2018
minimum co-financing per dose	0.31
your co-financing per dose (please change if higher)	

6.2.2.1.Specifications of vaccinations with new vaccine for routine cohort

	Source		2018
Number of girls in routine cohort to be vaccinated with the first dose	Table 5.2	#	612,966
Number of girls in routine cohort to be vaccinated with the second dose	Table 5.2	#	612,966
Immunisation coverage with the second dose	Table 5.2	%	80%
Country co-financing per dose	Table 6.2.2	$	0.31

6.2.2.2.Specifications of vaccinations with new vaccine for additional multi-age cohort

	Source		2018
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	1,974,330
Number of girls in the additional multi-age cohort to be vaccinated	Table 5.2	#	1,974,330

with the second dose			
Immunisation coverage with the second dose	Table 5.2	%	80.00%

6.2.3 Portion of supply for routine cohort to be procured by the country (and cost estimate, US$)

		2018
Number of vaccine doses	#	82,874
Number of AD syringes	#	115,092
Number of re-constitution syringes	#	0
Number of safety boxes	#	1,267
Total value to be co-financed by the Country ***[1]***	**$**	498,823

[1] The co-financing amount for intermediate and graduating countries indicates costs for the vaccines, related injection safety devices and any freight charges. The total co-financing amount does not contain the costs and fees of the relevant Procurement Agency, such as contingency buffer and handling fees. Information on these extra costs and fees will be provided by the relevant Procurement Agency as part of the cost estimate to be requested by the Country.

6.2.3.1 Portion of supply for routine cohort to be procured by Gavi (and cost estimate, US$)

		2018
Number of vaccine doses	#	1,143,058
Number of AD syringes	#	1,587,423
Number of re-constitution syringes	#	0
Number of safety boxes	#	17,461
Total value to be co-financed by Gavi	**$**	6,880,114

6.2.3.2 Portion of supply for additional multi-age cohort to be procured by Gavi (and cost estimate, US$)

		2018
Number of vaccine doses	#	2,587,296
Number of AD syringes	#	2,846,026
Number of re-constitution syringes	#	0
Number of safety boxes	#	31,307

6.2.4 New and Under-Used Vaccine Introduction Grant

Calculation of Vaccine Introduction Grant for the HPV quadrivalent, 1 dose(s) per vial, LIQUID

Year of New Vaccine Introduction	Girls in routine cohort (From Table 5.2)	Share per Girls in routine cohort in US$	Total in US$
2018	766,207	2.40	1,838,897

The Grant will be based on a maximum award of $2.4 per girl in the routine cohort with a minimum starting grant award of $100,000

Please describe how the Gavi Vaccine Introduction Grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the introduction of the new vaccine (refer to the cMYP and the Vaccine Introduction Plan).

The Gavi introduction grant will be used to facilitate various introduction and implementation activities for HPV vaccine for the routine cohort including:

1. Planning and Coordination
    - Facilitate coordination of the National Immunization Technical Working Group as well as its sub-committees (Training, Logistics, ACSM, Monitoring and Evaluation)
    - Development of training guide for health workers
    - Bottom-up microplanning
2. Advocacy, communication and social mobilization
    - National and county stakeholders' consultative forums
    - National and county HPV vaccine launches
    - Media Advocacy through newspapers, television and radio
    - Mobilization of teachers
    - Mobilization of community leaders
    - Mobilization of community through road shows and PAS
    - IEC materials
3. Service delivery
    - Training of health workers from National level to health facility level
    - outreach activities
4. Vaccine and logistics supply management
    - Cold chain capacity readiness assessment
    - Distribution of vaccines, syringes and safety boxes up to implementation level
    - Distribution of monitoring tools, IEC materials and training guides up to implementation level
5. Waste management
    - Provision of fuel and waste papers
6. Monitoring and evaluation
    - Printing of tools
    - Supportive supervision
    - Post introduction Evaluation

Please complete the 'Detailed budget for VIG / Operational costs' template provided by Gavi and attach as a mandatory document in the Attachment section.

Detailed budget attached as Document No. 22.

Where Gavi support is not enough to cover the full needs, please describe other sources of funding and the expected amounts to be contributed, if available, to cover your full needs.

6.2.5.New and Under-Used Operational support

Calculation of Operational Support for the HPV quadrivalent, 1 dose(s) per vial, LIQUID

Year of New Vaccine Introduction	Girls in additional multi-age cohort (From Table 5.2)	Share per Girls in additional multi-age cohort in US$	Total in US$
2018	2,467,913	0.55	1,357,352

Please describe how the Gavi Operational support will be used to reach the additional multi-age cohorts? How will these funds be used to strengthen routine activities e.g. reinforcing routine outreach activities, additional personnel, additional demand generation activities?

Note: These funds can be used over a longer period than the introduction year in order to strengthen routine immunisation. For example to reinforce routine outreach activities in difficult to access districts.

The Gavi Operational Support will be used to facilitate various introduction and implementation activities for HPV vaccine for the routine cohort including:

1. Advocacy, communication and social mobilization
    - IEC materials
2. Service delivery

    - outreach activities to reach multi-age cohort for both first and second doses
3. Vaccine and logistics supply management
    - Distribution of vaccines, syringes and safety boxes up to implementation level
    - Distribution of monitoring tools, IEC materials and training guides up to implementation level
4. Waste management
    - Provision of fuel and waste papers
5. Monitoring and evaluation

- Printing of additional tools for multi-age cohort

Detailed budget attached as Document No. 22.

Where Gavi support is not enough to cover the full needs, please describe other sources of funding and the expected amounts to be contributed, if available, to cover your full needs.

The overal budget (including provision for the multi-age cohort) budget currently has deficit of about $1,000,000. The Immunization Program will seek to bridge this gap through funding from the Government of Kenya, partners and through leveraging on other on-going strategies such as the HSS.

6.2.6.Technical assistance

Please describe any particular area(s) the Ministry would require technical assistance to support the introduction of HPV quadrivalent.

1. **Decision-making:** Support for KENITAG and especially the HPV working group, costing analysis and advocacy (WHO, CHAI, UNICEF)
2. **Best practices on HPV vaccination implementation:** WHO
3. **Application process:** CHAI, WHO, UNICEF
4. **Implementation:** WHO (Microplanning, Monitoring and Evaluation), UNICEF (Advocacy, communication and Social Mobilization, HPV vaccination strategy, Cold chain management), CHAI (Cold chain and vaccine supply managment)
5. **Evaluations:** Support for post-introduction evaluation (PIE)- WHO, CDC

7. NVS Preventive Campaigns

7.1. Assessment of burden of relevant diseases related to campaigns (if available)

Disease	Title of the assessment	Date	Results
Epidemic Meningitis	REPORT ON ASSESSMENT OF EPIDEMIC MENINGITIS RISK IN KENYA	November 2016	Kenya is in the Meningitis belt and is surrounded by neighbouring countries with history of epidemic meningitis. Also, Kenya has had a recent history of huge confirmed epidemic (1988 &1999) of about 3000 cases. Therefore Kenya still remains at risk of Epidemic meningitis. Quantitative data from national and sentinel surveillance still fail to show useable information. Experts confirm that Kenya remains at risk in the areas bordering Uganda, South Sudan and Ethiopia and recommend introducing the vaccine to boost population immunity and prevent Epidemic Meningitis due to Men A outbreaks

Please attach the Plan of Action for each campaign as Document No. 34 in Section 10.

7.1.1 Epidemiology and disease burden for Meningococcal A

Please select at least one of the following information sources to justify Meningococcal A disease burden results:

Epidemiological information on burden of disease:

☑ 1 - Risk assessments

☐ 2 - Other

7.2.Request for Meningococcal A, 10 dose(s) per vial, LYOPHILISED campaign support

7.2.1. Summary for Meningococcal A campaign support

When is the country planning to conduct the Meningococcal A catchup campaign? **February 2018**

When is the country planning to conduct this campaign? **February 2018**

Please note that, due to a variety of factors, the launch date may vary compared to the date stipulated in the application. Gavi will work closely with countries and their partners to address this issue.

Please give a summary of the cMYP and/or the Meningococcal A, 10 dose(s) per vial, LYOPHILISED introduction plan sections that refer to the introduction of Meningococcal A, 10 dose(s) per vial, LYOPHILISED. Outline the key points that informed the decision-making process (data considered etc) and describe the plans for social mobilisation and microplanning, including strategies for insecure or hard-to-reach areas. If they are included in the introduction plan or plan of action, please cite the sections only.

In order to reach the insecure areas, we will use local persons to map and mobilize the population. Furthermore, the choice of the health workers to deliver the vaccines will be informed by the local situation and sensitivities.

The other elements have been described in the introduction plan in the following sections: background on Men A, justification, microplanning and communication

Please summarise the cold chain capacity (at central and other levels) and readiness to accommodate new vaccines, taking into consideration training, cold chain **equipment** and other **logistical** requirements. If cold chain expansion is required, state how it will be financed, and when it will be in place. Please describe how the surge capacity for campaigns will be managed. Please indicate if the supplies for the campaign will have any impact in the shipment plans for your routine vaccines and how it will be handled. The Independent Review Committee requires assurance that the cold chain is ready or will be ready for the campaign, and evidence/plans need to be provided (if they are included in detail in the plan of action, please cite the section here). **All proposals** that include Gavi-financing for cold chain equipment intended for vaccine storage shall need to procure equipment pre-qualified by WHO under their Performance Quality and Safety (PQS) program. The purchase of non-PQS equipment will only be considered on an exceptional basis, with justification and advance agreement from Gavi. Please note that all Gavi-financed cold chain equipment needs to be WHO pre-qualified. The purchase of non-PQS equipment will only be considered on exceptional basis, with justification and advance agreement from Gavi.

Cold chain capacity description

Each dose has a cold chain volume of 2.6 cm3. For the population of 3,116,626, the total cold chain capacity required is about 9000 litres.

The Kenya vaccine cold chain is made of 1 central vaccine store located in Kitengela, Nairobi and 9 regional stores: Nairobi, Mombasa, Kisumu, Nakuru, Eldoret, Garissa, Meru, Kakamega and Nyeri. The regional stores which will be participating in the campaign are those in Eldoret and Garissa. Projections based on needs show a sufficient cold chain capacity at these regional depots. However, at subnational level, there is potential strain on the cold chain capacity. This situation can be mitigated through frequent collection/delivery of the vaccine from the regional depot. Further, arrangements will be made to reduce the stock holding of routine immunization vaccines in the month of MenAfriVac mass preventive campaign. Most of the target counties are priority counties for the upcoming CCEOP

Please describe how the campaign activities will contribute to strengthening routine immunisation services. Please refer to specific activities to be undertaken during planning and implementation, to evaluate the implementation of the routine strengthening activities completed during the campaign, and to assess, via an independent survey, the quality and coverage achieved through the campaign.

The training of health workers will provide an opportunity to build capacity of health workers on immunization planning, delivery and vaccine management. This will be a positive contribution of the vaccination campaign to routine immunization. During microplanning, the location and numbers of the target population will be mapped and area specific strategies on how to reach the target population will be developed. This is learnt from the 2016 MR vaccination campaign. This same information in future will be used to map out target population for the routine immunization target cohort.

The vaccination campaign can be used as a platform to deliver other vaccines for the same age group e.g.

HPV vaccine or to sensitize and refer clients to update their vaccination status.

The planned end of campaign independent monitoring will also assess vaccination status of individuals and ascertain coverage of other vaccines. This information will be used to strengthen routine immunization

Please submit relevant documentation to support the estimates of the size of the campaign target population (as DOCUMENT NUMBER : 18).

7.2.2. Grant Support for Operational Costs of the Meningococcal A Campaign

Table 7.2.2: calculation of grant to support the operational costs of the campaigns (mini catch up campaigns and mass campaigns)

Year of Meningococcal A support	Total target population (from Table 5.5)	Gavi contribution per target person in US$	Total in US$
2018	3,116,626	0.55	1,714,144

[1] The Grant will be based on a maximum award of 0.65 per target person- (synergies between mass campaigns, mini catch up campaigns and routine immunisation need to be highlighted. There will be common activities such as training across the new introductions).

Please describe how the grant will be used to facilitate the preparation and timely and effective delivery of the campaigns to the target population (refer to the cMYP and the Vaccine Introduction Plan).

The Gavi grant support for operational costs will facilitate various introductory activities which include:

- Planning and Coordination
  - Planning will be carried out at national, county and sub-county levels in preparation for the campaign.
  - The grant will facilitate coordination of the National Immunization Technical Working Group as well as its sub-committees (Training, Logistics, ACSM, Monitoring and Evaluation)
  - Development of vaccination guide for health workers
- Advocacy, communication and social mobilization
  - National and county stakeholder's consultative forums
  - National and county meningococcal vaccine launches
  - Media Advocacy through newspaper, television and radio
  - Mobilization of community leaders
  - Mobilization of community through road shows and PAS
  - IEC materials
- Service delivery including capacity building
  - Training of health workers
  - outreach activities
- Vaccine and logistics supply management
  - Cold chain capacity readiness assessment
  - Distribution of vaccines, syringes and safety boxes up to implementation level
  - Distribution of monitoring tools, IEC materials and training guides up to implementation level
- Waste management
  - Provision of fuel and waste papers
- Monitoring and evaluation
  - Printing of tools
  - Supportive supervision
  - Post introduction Evaluation
  - End of campaign independent monitoring.

Where Gavi support is not enough to cover the full needs, please describe other sources of funding and the expected amounts to be contributed, if available, to cover your full needs.

Funds will be sought from incountry immunization partners for the end of campaign independent monitoring activity.

Please complete the 'Detailed budget for VIG / Operational costs' template provided by Gavi and attach as a mandatory document in the Attachment section. VIG/operational costs template should detail or highlight activities for mini catch and comment on synergies across the VIGs).

Detailed budget attached as Document No. 22.

7.2.3 Meningococcal A Vaccine introduction Grant

Has a Meningococcal A vaccine already been introduced nationally on a routine basis? **Not selected**

Calculation of Vaccine Introduction Grant for the Meningococcal A, 10 dose(s) per vial, LYOPHILISED

Please indicate in the tables below how the one-time Introduction Grant***[1]*** will be used to support the costs of vaccine introduction and critical pre-introduction activities (refer to the cMYP). Gavi's support may not be enough to cover the full needs so please indicate in the table below how much and who will be complementing the funds needed.

Year of New Vaccine Introduction	Birth cohort (from Table 5.1)	Gavi contribution per target person in US$	Total in US$
2018	1,591,167	0.80	1,272,934

[1] The Grant will be based on a maximum award of $0.80 per person in the birth cohort with a minimum starting grant award of $100,000

Please describe how the Gavi Vaccine Introduction Grant will be used to facilitate the timely and effective implementation of critical activities in advance of and during the introduction of the new vaccine (refer to the cMYP and the Vaccine Introduction Plan).

8. NVS Follow-up Campaigns

No NVS Follow-up Campaign Support this year

9. Procurement and Management

9.1 Procurement and Management of New and Under-Used Vaccines Routine

Note: The PCV vaccine must be procured through UNICEF to be able to access the price awarded by the Advance Market Commitment (AMC).

a) Please show how the support will operate and be managed including procurement of vaccines (Gavi expects that most countries will procure vaccine and injection supplies through UNICEF or PAHO's Revolving Fund):

Government procurement systems follow the Public Procurement and Disposal Act 2005 and the Procurement Regulations of 2006 and this governs the procurement of all products financed by the Government. The regulations require that health products be procured through competitive tendering process. Procurement and supply of health products is managed by Kenya Medical

Supplies Agency (KEMSA). KEMSA is responsible and accountable for the procurement and distribution of syringes, safety boxes, and vaccine cold storage devices that are financed by Government.

All EPI vaccines are procured of through UNICEF including Gavi supported new and underutilized vaccines. The Government of Kenya and UNICEF work under a memorandum of understanding and UNICEF is contracted to procure Gavi funded vaccines as well as Kenya's co-payment of Gavi supported vaccines and traditional vaccines. HPV Vaccine will be procured through UNICEF SD.

The Government of Kenya also entered a financing arrangement with UNICEF, 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.

b) If an alternative mechanism for procurement and delivery of vaccine supply (financed by the country or the Gavi) is requested, please document

- A description of the mechanism and the vaccines or commodities to be procured by the country
- Assurance that vaccines will be procured from the WHO list of pre-qualified vaccines, indicating the specific vaccine from the list of pre-qualification. For the procurement of locally-produced vaccines directly from a manufacturer which may not have been prequalified by WHO, assurance should also be provided that the vaccines purchased comply with WHO's definition of quality vaccines, for which there are no unresolved quality problems reported to WHO, and for which compliance is assured by a fully functional National Regulatory Authority (NRA), as assessed by WHO in the countries where they are manufactured and where they are purchased.

c) If receiving direct financial support from Gavi (such as operational support for campaigns or VIG activities), please indicate how the funds should be transferred by Gavi.

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

The donor funds will be received by National Treasury through Central Bank of Kenya in the respective donor offshore account. The funds upon request by the implementing ministry are transferred through the exchequer system.

d) Please indicate how the co-financing amounts will be paid (and who is responsible for this)

Kenya pays its co-financing obligations through UNICEF and this will be the case with HPV vaccines.

e) Please describe the financial management procedures that will be applied for the management of the NVS direct financial support, including procurement.

The constitution of Kenya 2010 created a number of oversight independent constitutional bodies in the management of all public finances. This is strengthened by the Public Finance Management Act 2012. The objective is to ensure that all public finances, including donor funds are prudently utilized. The principal Secretary National Treasury is the government of Kenya principal accounting officer for all the funds which includes donor funds.

The donor funds will be received by National Treasury through Central Bank of Kenya in the respective donor offshore account. The funds upon request by the implementing ministry are transferred through the exchequer system Government procurement systems follow the Public Procurement and Disposal Act 2005 and the Procurement Regulations of 2006 and this governs the procurement of all products financed by the Government

The funds will also be managed according to the reporting requirements of the donor

f) Please outline how coverage of the introduced vaccine will be monitored, reported and evaluated (refer to cMYP and Introduction Plan)

The health sector has a well-established system of data collection and reporting with ongoing efforts aimed at improving data quality and use of data for decision making at all levels. The tools used to record vaccinations such as the permanent registers, tally sheets and summary sheets will be updated to include HPV. In addition, a vaccination card will be issued to targeted girls. When vaccination occurs, the records of the girl will be captured in the permanent register.

The data is transmitted from through the DHIS2 platform. The platform will be updated to include data points for HPV (HPV1 and HPV2 (six months apart)). Coverage for both first dose and second dose will be monitored as well as the dropout rate.

g) If applying for measles second dose, does the country wish to have the support in cash or in-kind? **N/A**

9.2 Procurement and Management for NVS Preventive Campaign(s)

9.2.1 Procurement and Management for Meningococcal A, 10 dose(s) per vial, LYOPHILISED campaign

a) Please show how the support will operate and be managed including procurement of vaccines (Gavi expects that countries will procure vaccine and injection supplies through UNICEF):

Procurement for MenAfriVac vaccine will be done through the UNICEF Supply Division as with other EPI vaccines. The MenAfriVac by Serum Institute of India Ltd, India. is WHO pre-qualified and is licensed in Kenya but needs to be retained by the manufacturer as annual requirement by the Pharmacy and Poisons Board (the National Regulatory Authority).

Once the vaccine is ordered through the UNICEF SD, UNICEF places the order and manages the freight forwarder in charge of the inbound transportation to Kenya. UNICEF provides copies of all shipping documents at least two weeks prior to arrival of vaccine to facilitate preparation of clearance documents and required finances.

b) Please describe the financial management procedures that will be applied for the management of the preventive campaign cash support, including any procurement to be incurred.

The constitution of Kenya 2010 created a number of oversight independent constitutional bodies in the management of all public finances. This is strengthened by the Public Finance Management Act 2012. The objective is to ensure that all public finances, including donor funds are prudently utilized. The principal Secretary National Treasury is the government of Kenya principal accounting officer for all the funds which includes donor funds.

The donor funds will be received by National Treasury through Central Bank of Kenya in the respective donor offshore account. The funds upon request by the implementing ministry are transferred through the exchequer system Government procurement systems follow the Public Procurement and Disposal Act 2005 and the Procurement Regulations of 2006 and this governs the procurement of all products financed by the

Government.

The funds will also be managed according to the reporting requirements of the donor

c) Please indicate if the campaign is going to be phased, and if so, how this will be done.

The Men A vaccination campaign will not be phased, but rather carried out at the same time in the 5 counties.

d) Please outline how coverage of the campaign including mini catch up campaigns will be monitored, reported and evaluated (refer to the cMYP and/or the Meningococcal A, 10 dose(s) per vial, LYOPHILISED campaign introduction plan)

Tools for data collection (data capture, summary and reporting) will be developed leveraging on experience from previous campaigns, printed and made available to the vaccinators. As with previous campaigns, data at the field level will be collected on paper. This will then be aggregated and entered into a customized electronic based tool at the county or sub-county level and transmitted electronically to a centralized server. Daily summaries on progress and achievements will feedback to different levels to inform plans for the subsequent days of the campaign.

Additionally, there will be supervisors at different levels who will be required to conduct in-process monitoring. Daily reviews will be conducted at the county and sub-county levels to review daily performance, challenges and make recommendations on how to improve the subsequent vaccination.

The campaign will be followed by a Post SIAs independent monitoring using acceptable methodology and this activity will be carried out by an independent entity from Ministry of Health.

9.3 Product Licensure

For each of the vaccine(s) requested, please state whether manufacturer registration and/or national vaccine licensure will be needed in addition to WHO prequalification and, if so, describe the procedure and its duration. In addition, state whether the country accepts the Expedited Procedure for national registration of WHO-prequalified vaccines.

Note that the necessary time for licensure should be factored into the introduction timeline and reflected in the Vaccine Introduction Plan or Plan of Action.

National vaccine licensure by the Pharmacy and Poisons Board will be required for HPV vaccine.
The Quadrivalent HPV vaccine manufactured by Merck Sharp & Dohme is licensed for use in the country.

National vaccine licensure by the Pharmacy and Poisons Board will be required for MenAfriVac Vaccine. The MenAfriVac by Serum Institute of India Ltd, India is currently licensed in Kenya but needs to be retained by the manufacturer as annual requirement by the Pharmacy and Poisons Board, Kenya. This is by paying annual retention fee.

For each of the vaccine(s) requested, please provide the actual licensure status of the preferred presentation and of any alternative presentations, if required.

The Kenya HPV vaccine to be introduced will be the Quadrivalent HPV vaccine manufactured by Merck Sharp & Dohme. The vaccine formulation is WHO prequalified and is licensed by the pharmacy and Poisons Board (PPB) for use in Kenya.

The MenAfriVac by Serum Institute of India Ltd, India is WHO pre-qualified and is licensed in Kenya but needs to be retained by the manufacturer as annual requirement by the Pharmacy and Poisons Board, Kenya

Please describe local customs regulations, requirements for pre-delivery inspection, special documentation requirements that may potentially cause delays in receiving the vaccine. If such delays are anticipated, explain what steps are planned to handle these.

Once the vaccine is ordered through the UNICEF SD, UNICEF places the order and manages the freight forwarder in charge of the inbound transportation to Kenya. UNICEF provides copies of all shipping documents at least two weeks prior to arrival of vaccine to facilitate preparation of clearance documents and

required finances.

The clearance of vaccines and delivery to the Central and Regional vaccines stores is outsourced to third-party logistics (3PL) distribution provider. The Ministry and the 3PL distribution provider have an agreement in place of 7 days from clearance to delivery. The amount of time the vaccine is held at the port of entry currently does not exceed 72 hrs. Once cleared, vaccines are transferred to the Central Vaccines Store and to the Regional Depots.

Please provide information on NRA in the country, including status (e.g. whether it is WHO-certified). Please include points of contact with phone numbers and e-mail addresses. UNICEF will support the process by communicating licensing requirements to the vaccine manufacturers where relevant.

The National Regulatory Authority in Kenya is the Pharmacy and Poisons Board. *The contact person is Dr Jonathan Meriakol +254 721 264 959 , Email: jmeriakol@pharmacyboardkenya.org*

9.4 Waste management

Countries must have a detailed waste management and monitoring plan as appropriate for their immunisation activities. This should include details on sufficient availability of waste management supplies (including safety boxes), the safe handling, storage, transportation and disposal of immunisation waste, as part of a healthcare waste management strategy. Please describe the country's waste management plan for immunisation activities (including campaigns).

The National policy of waste disposal is either incineration or burn and bury so all facilities will be required to follow this policy. All vaccines will be procured with adequate supply of AD syringes and safety boxes. These will be provided to all facilities before implementation of the campaign. The Meningococcal and HPV vaccination waste materials will be managed through the current injection safety and medical waste management policy. The sharps will be collected and kept in safety boxes with discarding of these waste to be either burn and bury at lower level facilities or incineration at higher level facilities

The waste management plan will include:

- Identification of waste disposal site and personnel responsible for waste management
- Estimation of the number of safety boxes needed
- Bundling of waste disposal boxes with vaccines and syringes during delivery
- Plan for the waste disposal sites and procedures for the disposal of all wastes generated irrespective of vaccination site
- Special attention will be made to ensure healthcare waste management in schools and other outreach sites are carried out according to best practices
- Plans for transportation and disposal of the waste from outreach posts such as schools.
- Include waste management in the training material and documentation
- Monitoring and evaluation of waste management to ensure waste management is carried out to a high standard

9.5 Procurement and Management for Follow up Campaign(s)

No NVS Follow-up Campaign Support this year

10. List of documents attached to this proposal

Table 1: Checklist of mandatory attachments

Document Number	Document	Section	File
Endorsements			
1	MoH Signature (or delegated authority) of Proposal	4.1.1	Document 1-Ministry of Health Signature.jpg **File desc:** **Date/time :** 24/05/2017 08:37:29 **Size:** 459 KB
2	MoF Signature (or delegated authority) of Proposal	4.1.1	Document 2- Ministry of Finance signature.jpg **File desc:** **Date/time :** 25/05/2017 03:47:20 **Size:** 66 KB
3	MoE signature (or delegated authority) of HPV Proposal	4.1.1	Document 3- Ministry of Education signature.jpg **File desc:** **Date/time :** 25/05/2017 03:42:30 **Size:** 66 KB
4	Terms of Reference for the Coordination Forum (ICC/HSCC or equivalent) including all sections outlined in Section 5.2 of the General Application Guidelines (Note: countries applying before May 2017 can submit their existing Terms of Reference)	4.1.2	Document 4 -Terms of Reference of ICC.pdf **File desc:** **Date/time :** 07/04/2017 09:11:02 **Size:** 399 KB
5	Minutes of Coordination Forum meeting endorsing Proposal	4.1.3	Document 5-Minutes of Child Health ICC 13.04.2017.docx **File desc:** **Date/time :** 30/04/2017 10:56:05 **Size:** 777 KB
6	Signatures of Coordination Forum members in Proposal	4.1.3	Document 6-ICC signature sheet.jpg **File desc:** **Date/time :** 03/05/2017 03:55:38 **Size:** 405 KB
7	Minutes of the Coordination Forum meetings from the past 12 months before the proposal	4.1.3	Document 7-Minutes of Special Child Health ICC 01.09.2016.docx **File desc:** **Date/time :** 30/04/2017 10:54:29 **Size:** 26 KB
8	Role and functioning of the advisory group, description of plans to establish a NITAG	4.2.1	Document 8-KENITAG TERMS OF REFERENCE .pdf **File desc:** **Date/time :** 03/05/2017 03:54:23 **Size:** 111 KB
26	List of areas/districts/regions and targets to be supported for meningitis A mini catch up campaigns		Document 26 List of Areas and Targets to be supported for Meningitis A.docx **File desc:** **Date/time :** 25/04/2017 01:39:57 **Size:** 13 KB

31	Minutes of NITAG meeting with specific recommendations on the NVS introduction or campaign	4.2	Document 31- Minutes of KENITAG Meeting April 2017.docx **File desc:** **Date/time :** 03/05/2017 04:11:25 **Size:** 834 KB
Planning, financing and vaccine management			
9	Comprehensive Multi Year Plan - cMYP	5.1	Document 9- Kenya_cMYP_2015.pdf **File desc:** **Date/time :** 07/04/2017 09:12:53 **Size:** 1 MB
10	cMYP Costing tool for financial analysis	5.1	Document 10 cMYP_Kenya costing tool for financial analysis.xlsm **File desc:** **Date/time :** 25/04/2017 01:43:46 **Size:** 1 MB
11	M&E and surveillance plan within the country's existing monitoring plan	5.1.4	Document 11. National MOH Monitoring and Evaluation_Framework - M&E Surveillance Plan.pdf **File desc:** **Date/time :** 26/04/2017 08:55:59 **Size:** 2 MB
12	New vaccine introduction plan (NVIP), New Vaccine Introduction Checklist and Activity List & Timeline for routine vaccines or Plan of Action (PoA) for campaign vaccines	5.1,7.2.3	Document 12-HPV New Vaccine Introduction Plan Checklist and Timeline.zip **File desc:** **Date/time :** 03/05/2017 07:54:21 **Size:** 803 KB
15	HPV Region/ Province profile	6.1.1	Document 15 HPV Application_Region Profile.xlsx **File desc:** **Date/time :** 25/05/2017 04:00:31 **Size:** 50 KB
16	HPV Key Stakeholder Roles and Responsibilities	6.1.1,6.1.2	Document 16 HPV Application_Stakeholder roles.xlsx **File desc:** **Date/time :** 25/04/2017 01:23:42 **Size:** 24 KB
18	Campaign target population documentation	8.x.1, 6.x.1	Document 18 Campaign Target Population.docx **File desc:** **Date/time :** 25/04/2017 01:59:43 **Size:** 13 KB
19	EVM report	9.3	Document 19 Effective Vaccine Management Assesment Report.pdf **File desc:** **Date/time :** 26/04/2017 08:32:49 **Size:** 1 MB
20	Improvement plan based on EVM	9.3	Document 20-EVM Improvement Plan (2013).xlsm **File desc:** **Date/time :** 25/04/2017 01:44:44 **Size:** 164 KB

21	EVM improvement plan progress report	9.3	Document 21. EVM-IP Progress Report - 2017 and EVM AWP update.xlsx **File desc:** **Date/time :** 26/04/2017 08:56:29 **Size:** 27 KB
22	Detailed budget template for VIG / Operational Costs	6.x,7.x.2,6.x.2,8.2.3	Document 22-HPV and Men A Budgeting and Planning Template.xlsm **File desc:** **Date/time :** 26/05/2017 02:47:21 **Size:** 1 MB
32	Data quality assessment (DQA) report	5.1.4	Document 32-Kenya Data Quality Audit 2014 Report.pdf **File desc:** **Date/time :** 25/04/2017 01:32:16 **Size:** 3 MB
34	Plan of Action for campaigns	8.1, 8.x.4	Document 34-Meningococcal A Conjugate (Men A) vaccine Plan of Action.docx **File desc:** **Date/time :** 26/05/2017 02:47:21 **Size:** 902 KB

Table 2: Checklist of optional attachments

Document Number	Document	Section	File
14	Annual EPI Plan with 4 year forward view for measles and rubella		No file loaded
17	Evidence of commitment to fund purchase of RCV (in place of the first dose of MCV) / for use in the routine system	5.1.6, 6.1.7	No file loaded
24	Risk assessment and consensus meeting report for Yellow Fever, including information required Section 5.3.2 in the General Guidelines on YF Risk Assessment process	5.1	No file loaded
25	Risk assessment and consensus meeting report for Yellow Fever, including information required in the NVS guidelines on YF Risk Assessment process	5.1	Not Applicable.pdf **File desc:** **Date/time :** 26/04/2017 04:29:15 **Size:** 11 KB
27	National Measles (& Rubella) elimination plan if available		No file loaded
28	A description of partner participation in preparing the application	4.1.3	No file loaded

30	For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, ICC minutes committing to finance from 2018 onwards.		Not Applicable.pdf **File desc:** **Date/time :** 26/04/2017 04:29:46 **Size:** 11 KB
33	DQA improvement plan	5.1.4	Document 33- Data quality improvement plan-Kenya.xls **File desc:** **Date/time :** 25/04/2017 01:30:20 **Size:** 93 KB
35	Other		Document 35 a-ALLOWANCES - CIRCULAR.docx **File desc:** **Date/time :** 26/05/2017 02:52:37 **Size:** 2 MB Document 35 b-Salararis and Remuneration-CIRCULAR.pdf **File desc:** **Date/time :** 26/05/2017 02:53:32 **Size:** 5 MB
36	Strategy for establishing or strengthening a national comprehensive approach to cervical cancer prevention and control		Document 36-Kenya National Cancer Control strategy.pdf **File desc:** **Date/time :** 25/04/2017 01:37:31 **Size:** 634 KB
37	Evidence of self-financing MCV1	5.1.5	No file loaded
38	For countries applying for measles/rubella support that are not yet financing the measles monovalent component of MCV1, a signed letter from the Minister of Health and the Minister of Finance committing to finance from 2018 onwards.		No file loaded
39	Epidemiological analysis/evidence	8.3.1	No file loaded
40	Post Campaign Coverage Survey report for MR catch-up applications	5.1.x	No file loaded
41	cMYP addendum on measles and rubella		No file loaded

11. Annexes

Annex 1 - NVS Routine Support

Annex 1.1 HPV quadrivalent, 1 dose(s) per vial, LIQUID

Table Annex 1.1 A: Rounded up portion of supply that is procured by the country and estimate of relative costs in US$

		2018
Number of vaccine doses	#	82,874
Number of AD syringes	#	115,092
Number of re-constitution syringes	#	0
Number of safety boxes	#	1,267
Total value to be co-financed by the Country ***[1]***	$	498,823

Table Annex 1.1 B: Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US$

Portion of supply for routine cohort to be procured by Gavi (and cost estimate, US$)

		2018
Number of vaccine doses	#	1,143,058
Number of AD syringes	#	1,587,423
Number of re-constitution syringes	#	0
Number of safety boxes	#	17,461
Total value to be co-financed by Gavi	$	6,880,114

Portion of supply for additional multi-age cohort to be procured by Gavi (and cost estimate, US$)

		2018
Number of vaccine doses	#	2,587,296
Number of AD syringes	#	2,846,026
Number of re-constitution syringes	#	0
Number of safety boxes	#	31,307

Table Annex 1.1 C: Summary table for vaccine HPV quadrivalent, 1 dose(s) per vial, LIQUID

	Source		2018
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	1,974,330
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	1,974,330
Immunisation coverage with the second dose	Table 5.2	%	80.00%

Table Annex 1.1 D: Estimated numbers for HPV quadrivalent, 1 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 1)

		Formula	2018		
			Total	Government	Gavi
A	Country co-finance	*V*	6.76 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	612,966	41,437	571,529
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	612,966		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	1,225,932	82,874	1,143,058
E	Estimated vaccine wastage factor	*Table 5.2*	1.05		
F	Number of doses needed including wastage	*D x E*	1,287,229	87,018	1,200,211
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	321,808	21,755	300,053
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	1,609,100	108,777	1,500,323
J	Number of doses per vial	*Vaccine parameter*	1		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	1,702,515	115,092	1,587,423
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	18,728	1,267	17,461
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	7,240,950	489,493	6,751,457
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	61,291	4,144	57,147
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	8,631	584	8,047
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	68,065	4,602	63,463
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	7,378,937	498,823	6,880,114
U	Total country co-financing	*I x country co-financing per dose (cc)*	498,821		
V	Country co-financing % of Gavi supported proportion	*U / T*	6.76 %		

Annex 2 - NVS Routine – Preferred Second Presentation

Annex 2.1 - NVS Routine Support (HPV bivalent, 2 dose(s) per vial, LIQUID)

Table Annex 2.1 A: Rounded up portion of supply that is procured by the country and estimate of relative costs in US$

		2018
Number of vaccine doses	#	81,089
Number of AD syringes	#	112,613
Number of re-constitution syringes	#	0
Number of safety boxes	#	1,239
Total value to be co-financed by the Country *[1]*	$	498,823

Table Annex 2.1 B: Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US$

Rounded up portion of supply for the additional cohort that is procured by Gavi and estimate of relative costs in US$

		2018
Number of vaccine doses	#	1,144,843
Number of AD syringes	#	1,589,902
Number of re-constitution syringes	#	0
Number of safety boxes	#	17,489
Total value to be co-financed by Gavi	$	7,042,537

Table Annex 2.1 B: Rounded up portion of supply that is procured by Gavi and estimate of relative costs in US$ ADDITIONAL COHORTS

		2018
Number of vaccine doses	#	612,966
Number of AD syringes	#	674,263
Number of re-constitution syringes	#	0
Number of safety boxes	#	7,417

Table Annex 2.1 C: Summary table for vaccine HPV bivalent, 2 dose(s) per vial, LIQUID

	Source		2018
Number of girls in the additional multi-age cohort to be vaccinated with the first dose	Table 5.2	#	0
Number of girls in the additional multi-age cohort to be vaccinated with the second dose	Table 5.2	#	0
Immunisation coverage with the second dose	Table 5.2	%	0

Table Annex 2.1 D: Estimated numbers for HPV bivalent, 2 dose(s) per vial, LIQUID, associated injection safety material and related co-financing budget (page 1)

		Formula	2018		
			Total	Government	Gavi
A	Country co-finance	*V*	6.61 %		
B	Number of children to be vaccinated with the first dose	*Table 5.2*	612,966	40,545	572,421
B1	Number of children to be vaccinated with the second dose	*Table 5.2*	612,966		
C	Number of doses per child	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B + B1*	1,225,932	81,089	1,144,843
E	Estimated vaccine wastage factor	*Table 5.2*	1.05		
F	Number of doses needed including wastage	*D x E*	1,287,229	85,144	1,202,085
G	Vaccines buffer stock	*Buffer on doses needed = (D - D of previous year) x 25% Buffer on wastages = ((F - D) - (F of previous year - D of previous year)) x 25%, = 0 if negative result G = [buffer on doses needed] + [buffer on wastages]*	321,808	21,286	300,522
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	1,609,100	106,434	1,502,666
J	Number of doses per vial	*Vaccine parameter*	2		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	1,702,515	112,613	1,589,902
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	0	0	0
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	18,728	1,239	17,489
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	7,401,860	489,594	6,912,266
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	61,291	4,055	57,236
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	0	0	0
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	8,631	571	8,060
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	69,578	4,603	64,975
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	0	0	0
T	Total fund needed	*(N+O+P+Q+R+S)*	7,541,360	498,823	7,042,537
U	Total country co-financing	*I x country co-financing per dose (cc)*	498,821		
V	Country co-financing % of Gavi supported proportion	*U / T*	6.61 %		

Annex 3 - NVS Preventive campaign(s)

Annex 3.1 - NVS Preventive campaign(s) (Meningococcal A, 10 dose(s) per vial, LYOPHILISED)

Table Annex 3.1 C: Summary table for CAMPAIGN Meningococcal A, 10 dose(s) per vial, LYOPHILISED

	Source		2018
Total target population	Table 5.2	#	3,116,626
Number of doses per persons	Parameter	#	1
Estimated vaccine wastage factor	Table 5.2	#	1.11
Wastage Rate	Table 6.2.2	#	10
Number of doses per vial	Parameter	#	10
AD syringes required	Parameter	#	Yes
Reconstitution syringes required	Parameter	#	Yes
Safety boxes required	Parameter	#	No
AD syringe price per unit	Table Annexes 4A	$	0.036
Reconstitution syringe price per unit	Table Annexes 4A	$	0.031
Safety box price per unit	Table Annexes 4A	$	0.461
Freight cost as % of vaccines value	Table Annexes 4B	%	0.19%
Freight cost as % of devices value	Parameter	%	10.00%

Table Annex 3.1 D: Estimated numbers for Meningococcal A, 10 dose(s) per vial, LYOPHILISED, associated injection safety material and related co-financing budget (page 1)

		Formula	2018		
			Total	Government	Gavi
B	Total target population	*Table 5.3.1*	3,116,626	0	3,116,626
C	Number of doses per persons	*Vaccine parameter (schedule)*	1		
D	Number of doses needed	*B x C*	3,116,626	0	3,116,626
E	Estimated vaccine wastage factor	*100 / (100 - Vaccine wastage rate)*	1.11		
F	Number of doses needed including wastage	*D x E*	3,459,455	0	3,459,455
G	Vaccines buffer stock	*0*	0	0	0
I	Total vaccine doses needed	*Round up((F + G) / Vaccine package size) * Vaccine package size*	3,459,500	0	3,459,500
J	Number of doses per vial	*Vaccine parameter*	10		
K	Number of AD syringes (+ 10% wastage) needed	*(D + G) x 1.10*	3,428,289	0	3,428,289
L	Reconstitution syringes (+ 10% wastage) needed	*(I / J) x 1.10*	380,546	0	380,546
M	Total of safety boxes (+ 10% of extra need) needed	*(K + L) / 100 x 1.10*	0	0	0
N	Cost of vaccines needed	*I x vaccine price per dose (g)*	1,954,618	0	1,954,618
O	Cost of AD syringes needed	*K x AD syringe price per unit (ca)*	123,419	0	123,419
P	Cost of reconstitution syringes needed	*L x reconstitution price per unit (cr)*	11,671	0	11,671
Q	Cost of safety boxes needed	*M x safety box price per unit (cs)*	0	0	0
R	Freight cost for vaccines needed	*N x freight cost as of % of vaccines value (fv)*	3,714	0	3,714
S	Freight cost for devices needed	*(O+P+Q) x freight cost as % of devices value (fd)*	13,509	0	13,509
T	Total fund needed	*(N+O+P+Q+R+S)*	2,106,931	0	2,106,931

Note: There is no co-financing for NVS preventive campaigns

Annex 4

Table Annex 4A:Commodities costs

Estimated prices of supply are not disclosed

Vaccine	Presentation	2017	2018	2019
HPV quadrivalent, 1 dose(s) per vial, LIQUID	1	4.500	4.500	4.500
Meningococcal A, 10 dose(s) per vial, LYOPHILISED	10	0.565	0.565	0.565

Supply	Form	2017	2018	2019
RECONSTIT-SYRINGE-YF	SYRINGE	0.031	0.031	0.031

Note: WAP - weighted average price (to be used for any presentation: For DTP-HepB-Hib, it applies to 1 dose liquid, 2 dose lyophilised and 10 dose liquid. For Yellow Fever, it applies to 5 dose lyophilised and 10 dose lyophilised)

Table Annex 4B: Freight cost as percentage of value

Vaccine Antigen	Vaccine Type	2018
HPV quadrivalent, 1 dose(s) per vial, LIQUID	HPV	0.94 %
Meningococcal A, 10 dose(s) per vial, LYOPHILISED	MENINACONJUGATE	0.19 %

Table Annex 4C: Preparatory transition phase - Minimum country co-payment per dose of co-financed vaccine

Vaccine	2018
HPV quadrivalent, 1 dose(s) per vial, LIQUID	0.31

12. Banking Form

In accordance with the decision on financial support made by the Gavi, the Government of Kenya hereby requests that a payment be made via electronic bank transfer as detailed below:

Name of Institution (Account Holder):			
Address:			
City Country:			
Telephone no.:		**Fax no.:**	
		Currency of the bank account:	
For credit to:			
Bank account's title:			
Bank account no.:			
Bank's name:			

Is the bank account exclusively to be used by this program?

By who is the account audited?

Signature of Government's authorizing official

		Seal
Name:		
Title:		
Signature:		
Date:		

FINANCIAL INSTITUTION		**CORRESPONDENT BANK (In the United States)**	
Bank Name:			
Branch Name:			
Address:			
City Country:			
Swift Code:			
Sort Code:			
ABA No.:			
Telephone No.:			
FAX No.:			

I certify that the account No is held by at this banking institution

The account is to be signed jointly by at least (number of signatories) of the following authorized signatories:

1		
	Name:	
	Title:	
2		
	Name:	
	Title:	
3		
	Name:	
	Title:	

Name of bank's authorizing official
Signature:
Date:
Seal: