Joint SDG Fund – 1st Call on SDG Financing

Component 2 Joint Programme

A. COVER PAGE

1. Fund Name: Joint SDG Fund

2. MPTFO Project Reference Number

3. Joint programme title: Championing the World's first Adolescent Sexual Reproductive Health Development Impact Bond in Kenya

4. Short title: ASRH Development Impact Bond in Kenya

5. Country and region: ASRH Development Impact Bond in Kenya

6. Resident Coordinator: Dr. Stephen Jackson, stephen.jackson@un.org

7. RCO Joint Programme focal point: Mr. Arif Neky, Senior Advisor for UN Strategic Partnerships and Coordinator of the SDG Partnership Platform, arif.neky@one.un.org

8. Lead agency Joint Programme focal point: Dr. Ademola Olajide, Representative UNFPA Kenya, olajide@unfpa.org

9. Government Joint Programme focal point: H.E. Prof. Peter Anyang' Nyong'o, Governor Kisumu County and Chairman-Health Committee, Council of Governors, nyongoanyang@gmail.com

10. Type of financial intervention: Development Impact Bond (DIB)

11. Short description:

This Joint Programme (JP) will support the scale up of the world's first Adolescent Sexual and Reproductive Health (ASRH) development impact bond in Kenya. It will leverage PUNOs expertise to ensure public sector integration of an innovative, digital-based proof of concept intervention named "In Their Hands" (ITH), which has demonstrated strong results in reaching adolescent girls with critical lifesaving SRH and HIV services in the private sector, since 2017.

The Programme will address critical gaps in access to SRH and HIV services by adolescent girls in vulnerable local contexts in Kenya, by improving quality of service delivery in public

health facilities; leveraging on technology to expand choice and reach of services; increasing pathways for specialized services such as HIV treatment; and scaling up investable healthcare opportunities for the private investors whilst stimulating more public investment into adolescent health. These actions are expected to translate into increased access to quality and sustainable SRH and HIV services by vulnerable adolescent girls in Kenya, with the Government leading the way. The programme will also provide proof of impact per dollar, and efficacy data as well as creating an operating and financing model which can be replicated to address SRH needs in other contexts. A UNFPA-managed SRH outcome fund will be created to oversee this process beyond the duration of the JP, which will also translate into increased uptake of innovative financing mechanisms in the future within the UN locally and globally. These initiatives will also lead to expanded funding prospects for adolescent health and consequently increase the agency for supporting adolescent girls.

12. Keywords: DIB, Adolescent, Reproductive Health, Innovative Financing, SDG3, Kenya

13. Overview of budget

Joint SDG Fund contribution	**USD 7,000,000**
Co-funding committed X	USD 000.00
Co-funding anticipated X	USD 13,901,988
TOTAL	**USD 20,901,989.00**
Co-financing X	USD18,351,988.00
Co-financing ratio (1: Total/SDG Fund Contribution)	1 : 2.62

14. Timeframe:

Start date	**End date**	**Duration (in months)**	**Phase**
1st April 2022	30th March 2023	12 months	Inception
1st April 2023	31st March 2026	36 months	Implementation

15. Gender Equality Marker: **2**

16. Participating UN Organizations (PUNO) and Partners:

16.1 PUNO

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UN SIGNATURE PAGE

Resident Coordinator

Dr. Stephen Jackson, Resident Coordinator

Date 29 [redacted]

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Participating UN Organization (lead/convening)

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Dr. Ademola Olajide,

Date 29-Oct-2021

Signature and seal [redacted]

Participating UN Organization

The Joint United Nations Programme on HIVAIDS (UNAIDS)

Dr. Medhin Tsehaiu,

Date: 29/10/2021

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Signature and seal

Participating UN Organization

World Health Organization (WHO)

Dr. Juliet Nabyonga,

Date 28th October 2021

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GOVERNMENT SIGNATURE PAGE

National Coordinating Authority

Council of Governors

H. E Prof. Peter Anyang' Nyong'o

Chairperson, Health Committee

Date: 1st November, 2021

[redacted]

B. STRATEGIC FRAMEWORK

1. Call for Joint Programmes: SDG Financing (2020) – Component 2

2. Programme Outcome [preselected]

- Additional financing leveraged to accelerate SDG achievement (Joint SDG Fund Outcome 2)

3. UNDAF Outcomes and Outputs

3.1 Outcomes

- By 2022, Kenya has increased and ensured equitable access to quality health services including Sexual Reproductive Maternal New-born Child Adolescent Health (SRMNCAH) in emergency and non-emergency settings
- By 2022, all women, men and children in need, including key and priority populations, have equitable access to quality HIV prevention, treatment and care services
- By 2022 people in Kenya access high-quality services at devolved level that are well coordinated, integrated, transparent, equitably resourced and accountable
- By 2022, marginalized vulnerable groups and regions in Kenya have increased access to decent jobs, income and entrepreneurship opportunities

3.2 Outputs

- Adolescents and young people are empowered to make informed decisions about their Sexual and Reproductive Health and Rights (SRHR) and to protect themselves from SRHR risks such as teenage pregnancies and new HIV infections
- Adolescents and young people have access to contraception and are able to prevent unintended pregnancies including repeat pregnancies, among first time young mothers
- Adolescents and young people access to HIV testing, know their status, are linked to and sustained on acceptable, affordable and quality HIV prevention and treatment interventions
- Increased financing for adolescent SRHR programmes from both public and private sources

4. SDG Targets directly addressed by the Joint Programme

4.1 List of goals and targets

Goal #3: Ensure healthy lives and promote well-being for all at all ages

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases and other communicable diseases

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

Goal #5: Achieve gender equality and empower all women and girls

5.6 By 2030, ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference

on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

Goal #17: Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

17.3 By 2030, mobilize additional financial resources for developing countries from multiple sources

17.17 By 2030, encourage and promote effective public, public-private and civil society partnerships, building on the experience and resourcing strategies of partnerships

4.2 Expected SDG impact

New strategic partnerships established and innovative models for improved financing and delivery of quality Sexual Reproductive Health and HIV Services to vulnerable adolescent girls adopted, contributing to gender equality and empowerment of women and girls, and healthy lives and well-being for all.

5. Relevant objective(s) from the national SDG framework

The project is aligned with the long-term National development plan (Kenya's Vision2030) and related strategies as Medium Plan 3 and the President's Big Four Agenda, including those specific for the Health Sector (Kenya Health Sector Strategic Plan 2018–2023, National Adolescent Reproductive Health Policy 2015), Kenya AIDS Strategic Framework 2021–2025, Kenya National Healthcare Financing Strategy and the National Domestic Resource Mobilization Blueprint for UHC (DRM UHC). Key objectives include:

a. To finance health in a sustainable manner through use of innovative domestic financing approaches and leveraging on ICT to achieve improved value for money
b. To increase equitable access and utilization of quality integrated Sexual and Reproductive Health and Rights (SRHR) and HIV information and services among adolescents and young people.
c. To increase efficiency in delivery of healthcare services among the vulnerable and hard to reach population.

6. Trans-boundary and/or regional issues

Kenya is part of the East and Southern Africa (ESA) Region and a member of the East African Community (EAC). In 2013, Kenya and 19 other ESA countries signed the Inter-Ministerial Commitments on Comprehensive Sexuality Education (CSE) and SRHR services for young people, commonly known as "ESA Commitments". These commitments were aimed at preventing new HIV infections; early and unintended pregnancies; and eliminating GBV and child marriages among young people by 2020. Despite coming to an end in 2020, the ESA commitments played a major role in aligning the efforts of ESA countries to promote adolescent SRH. A review process has been initiated under the leadership of the EAC with an ambition to have in place a new framework for the period between 2021-2030. Kenya is part of this conversation and adoption of the renewed commitments will ensure that the environment for provision of SRH and HIV information and services to adolescents remains conducive.

C. JOINT PROGRAMME DESCRIPTION

1. Baseline and Situation Analysis

1.1 Problem statement (max 1 page)

Teen pregnancy and HIV are among the major drivers of morbidity and mortality among adolescents, in particular adolescent girls, and often result in a lifetime of missed education and employment opportunities. This lost opportunity limits the full potential of countries with large youthful populations, like most countries such as Kenya in Sub-Saharan Africa.

Kenya is a youthful nation with 75% of its population being below the age of 35. With the right investments in human capital, especially if young people are empowered to take control of their health, the country can reap a *demographic dividend*. Young people in Kenya, however, continue to experience negative health outcomes relative to the overall population. Those aged between 15 and 24 years for instance account for 42% of the overall adult new HIV infections concentrated in high HIV prevalent counties in the Country, while half of sexually active teens don't know their HIV status. Moreover, one in every five adolescent girls between the ages of 15–19 is either pregnant or is already a mother, with about 330,000 girls (10-19 years) becoming pregnant every year. This grim picture points to the fact that adolescent girls are underserved and underequipped to face their challenges in upholding their sexual and reproductive rights.

The main barriers preventing adolescent girls from accessing Sexual and Reproductive Health (SRH) and HIV services are affordability, lack of information, distance to health facilities, legal and policy related barriers, child marriages, and other societal deterrents. In instances where services are accessible, poor user experience attributed to unfriendliness of healthcare services to adolescents and lack of provider choice, leads to inconsistency in uptake of services. A case in point is adolescents on HIV care and treatment who have poor treatment outcomes due to adherence and retention challenges

Widening poverty, barriers in education attainment, and inadequate investments in adolescent SRH programmes further compound the situation. Whilst there are several major SRH funders in Kenya, few are focused on adolescents. Additionally, as Kenya climbs the middle-income ladder, development assistance is declining (as donors shift from aid to trade and public funds are increasingly constrained by high debt repayments and recurrent costs), requiring the country to seek new and innovative ways to finance its development agenda. This critical transition from SDF Funding to financing has been highlighted by the UN Secretary General under the UN Reform Agenda as well. Whilst there is a widespread interest from private investors in Kenya, there are too few credible investable opportunities in health and, more broadly, in social investment. Currently, the Ministry of Health is in the process of developing the Kenya Health sector transition roadmap that will guide its sustainability agenda. The transformation of the National Hospital Insurance Fund (NHIF) as part of the journey towards Universal Health Coverage (UHC) will also play a critical role in increasing coverage and access to affordable SRH services in the country. The successes of these ambitions will nonetheless call for deliberate action to try and leverage innovative financing and service delivery models that inform practice.

Meanwhile, efforts to address unintended pregnancies, new HIV infections and AIDS-related deaths among adolescents must be doubled in line with ICPD25 national commitments, to ensure that the country remains on course to attaining Vision 2030, and SDG goals 3, 5 and 17.

1.2 Related interventions (max 1 page)

The JP builds on the In Their Hands (ITH) programme implemented by Triggerise that forms the basis of the proposed JP. ITH was created in 2017 with support from the Children's Investment Fund Foundation (CIFF) and implemented in 2018 and 2019 for proof of concept. The programme was further scaled up in 2020 when FCDO and CIFF launched the first tranche of the ASRH Development Impact Bond ('First ASRH DIB) designed in collaboration with the SDG Partnership Platform (SDGPP). The DIB's feasibility study concluded that ITH's own output and short-term outcome data since inception made it pre-financeable by risk-taking investors. But the study also highlighted the need for the programme to reach much larger scale and to continue improving its business model in order to durably reduce costs per user to affordable levels, as an essential condition for the programme to harness diversified funding over the long term. The ITH) programme is currently connected to 173 private clinics and 74 pharmacies and has so far enrolled over 750,000 girls with 550,000 receiving SRH and HIV services and more than 80% of them rating these services. The cost per user has also halved through increase in scale and business model improvements. Attaining sustainability, however, remains a critical priority area for this innovative initiative. The JP therefore seeks to address this concern by leveraging UN's convening power to secure government and broader stakeholder buy in for the programme. This will entail integration of the model in the public sector and exploring public purchase options for services rendered in the private sector through the national insurer. It will also seek to address the existing gap between HIV testing and treatment by strengthening the treatment cascade.

The proposed programme is also related to the Joint UN programme on HIV and AIDS and the Joint UN H6 programme on Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH) 2017–2020. These programmes have strategically positioned the UN as the anchor convener and trusted partner to the government in ensuring equitable access to SRH services especially to those furthest behind, and in protection of the most at-risk populations from HIV and adverse effects of AIDS. Some of the key lessons drawn from the programme include the value of 'delivering as one' based on comparative strengths; the importance of adopting a whole system approach including genuine public-private collaboration in strengthening the delivery of healthcare services; the significance of using data to inform programme implementation sites; and the value of working with counties to strengthen delivery of SRH/HIV services. However, one of the main gaps experienced was coordination given the number of players involved and the crosscutting nature of some agency programme components. To address this gap, the JP will ensure clear division of labour and clarity of roles among all partners in delivering the JP. Similarly, the JP has been co-created with the target counties to ensure that priority is given to areas with priority needs in the spirit of leaving no one behind and that partnerships are well harmonized.

The SDGPP's Primary Health Care (PHC) window established in 2017, in support of Kenya's UHC ambition under the Big Four Agenda, is another related intervention. For the past three years, the platform has been driving thought leadership based on research; facilitated public private dialogue; built Public Private Partnerships (PPPs) capacities; and fostered selected PHC partnerships to transition from funding to financing. The experience so far is that, whilst there is political will to partner and engage in innovative financing for PHC/UHC, the lack of operational experience and real examples of successful public-private initiates is hampering progress. Development partners are keen to look much deeper into this space and consider blended financing to help Kenya graduate from ODA to more sustainable domestic financing for the health agenda, but implementable solutions with successful track records are scarce to come by. The JP will be keen to demonstrate the potential of expanding public-private capital flows for investing in adolescent health.

1.3 SDGs and targets (max 1 page)

Targets for SDG 3: Ensure healthy lives and promote well-being for all at all ages

- By 2030, reduce global maternal mortality ratio (MMR) to less than 70/100,000 live births
- By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases, and other communicable diseases.
- By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Indicators, baseline and measurement method:

- MMR (Baseline-362/100,000). Measurement – Kenya Demographic & Health Survey (KDHS), Kenya Health Information System
- Number of new HIV infections per 1,000 uninfected populations, by sex, age and key populations *(Baseline-1.8/1000) – Measurement-Kenya AIDS Response Progress Report*
- Proportion of married women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods *(Baseline (15–19 years)-76.6%) – KDHS, programme survey*
- Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1,000 women in that age group *(Baseline (15–19)-96/1000) – Measurement-KDHS, KHIS*

Targets for Goal 5: Achieve gender equality and empower all women and girls

- By 2030, ensure Universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

Indicator, baseline and measurement method: Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive healthcare *(Baseline-)-Measurement-Programme survey.*

Targets for Goal 17: Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development

- By 2030, mobilize additional financial resources for developing countries from multiple sources.
- By 2030, encourage and promote effective public, public-private and civil society partnerships, building on the experience and resourcing strategies of partnerships.

Indicator, baseline and measurement method: Amount of US dollars committed to public-private and civil society partnerships *(Baseline 0, measurement method – First ASRH DIB programme evaluation).*

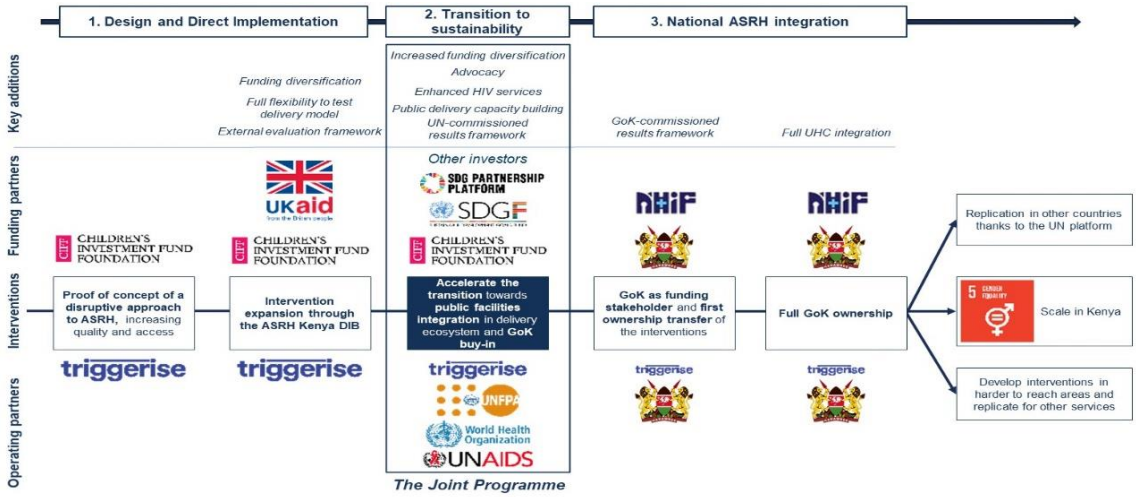
The JP seeks to address the problem of teenage pregnancy, new HIV infections and AIDS related deaths among adolescent girls by leveraging strategic private-public partnerships to improve quality of ASRH and HIV services and unlock resources towards the SDG targets. By tackling these poor health outcomes, there will be an improvement in education outcomes (enrolment, retention, completion and transition); the contribution of young people to economic development will be enhanced; and there will be reduced dependency.

2. Programme Strategy

2.1 Theory of Change (max 2 pages, including graphic)

This JP's overarching mission is to empower 15 to 19-year-old Kenyan girls by providing them with key tools and services to fulfil their potential, ultimately paving the way for improved gender equality across Kenya. We propose to reach this goal by leveraging the JP parties' respective unique strengths to catalyse sustainable integration of quality ASRH services in Kenya's Universal Health Coverage (UHC).

The JP will increase the scale and scope of services offered by Triggerise through the In Their Hands programme (ITH), an innovative adolescent-centred digital-based SRH solution *(see section 2.2. Proposed intervention)*, and will engage with the Government of Kenya (GoK) on multiple levels to ensure embedding in the Kenya's public health response on exit. Financing through a DIB will strengthen the programme's sustainability prospects by broadening the range of private and public investors ready to invest in Kenyan ASRH and paving the way for increased GoK participation. As illustrated in the graphic representation of our vision below, this JP intervenes at a critical juncture in ITH's trajectory to sustainability.



To reach the goal of sustainable and equitable access to qualitative SRH services, HIV testing and linkages to treatment for adolescent girls in Kenya, the UN agencies and the One-UN SDGPP within the JP have partnered with Triggerise, the implementer of ITH. While ITH has achieved great success so far *(see section 2.8. Progress)*, the last two years of operations at scale have uncovered two key barriers to reach the goal of sustainable and equitable access: (i) the difficulty to reach marginalized users and to sustain usage and (ii) the need for sustainable access to a diversified pool of private and public funding, including Kenyan public funding. The JP will overcome the first barrier by implementing a range of activities[1] aimed at increasing service uptake as well as improving service quality and accessibility *(as outlined in the ToC diagram in Annex 5)*. Notably, the programme will expand its ecosystem of service providers; increase the provision of HIV and SRH services to vulnerable adolescent girls in line with GoK health policy priorities and increase quality standards and assurance in public health facilities. In parallel, financing through a Development Impact Bond will contribute to long-term financial sustainability by broadening the range of private and public investors ready to invest in ASRH as well as contribute to increased GoK funding and participation[1] *(see*

[1]Corresponding to the 5 main pillars of interventions further detailed in the proposed interventions section 2.2.: demand generation, delivery model transition, quality assurance, stakeholder engagement and evidence generation, and funding model transition

section 2.2. Proposed intervention for further details). This DIB is the first step towards funding model transition and will generate reliable evidence of the performance of ITH. These will be used to support advocacy activities aimed at generating additional financial commitments by the GoK and ease limits of NHIF enrolment and reimbursements, thereby advancing GoK's Health agenda.

Every step of the programme and DIB implementation will be designed to contribute to the generation of the following outcomes, which have been selected based on their alignment with the GoK's strategic priorities, and are thus critical to accelerate government buy-in:

- Sexual and Reproductive Health: (i) increased and sustained use of Sexual and Reproductive Health services, (ii) reduced adolescent pregnancy rates;
- HIV: (i) improved HIV treatment adherence rates, (ii) reduced new HIV infections among adolescents and <24-year youth, (iii) reduction in AIDS-related deaths;
- Quality and efficiency: (i) increased quality scores (youth friendliness) across the private and public clinic ecosystem, (ii) strengthened ability of public units to participate in user-driven solutions.

We expect that the systematic implementation of the programme described above will, by the end of the JP:

- Sustain behaviour change by making health choices relevant to girls' aspiration, their life goals and their future earning potential;
- Influence the Kenyan health system's response to commit continuous and sufficient public funding to adolescent healthcare by providing a user-centric model and demonstrating the positive effects of results-based financing models for adolescent health and successful public-private partnerships.

The implementation of the JP will enable a first ownership transfer to the Government of Kenya, which means (i) fully compliant services with Global healthcare quality standards and with the national health framework, (ii) increased leadership of public players in delivering quality ASRH services, (iii) scaled down user rewards as a premise to systemic changes in behaviour and perceptions, (iv) Triggerise transitions towards a quality control focus alongside powering the technology, (v) increased domestic funds allocation to ASRH with NHIF paying the private providers directly, (vi) significantly lower need for external grant funding. Our longer-term ambition is full ownership and leadership by the government with (i) readily accessible services to all adolescents, (ii) full integration within Kenya's UHC, (iii) free service as a sufficient incentive for girls to access the services, (iv) full-know-how transfer with Triggerise providing technical assistance when needed, (v) automatic and sufficient fund allocation from counties, (vi) private funding only directed towards pilot operations, complementary initiatives and enhancements to support the Government to expand or replicate the programme.

The main assumptions behind this ToC include: (i) by addressing ASRH, girls will be more likely to complete their education and participate in community activities, (ii) adolescent girls can only make informed choices on their SRH if they have easy access to accurate information about ARSH and HIV care that is in line with their needs and circumstances and are able to understand and use this information to change their behaviours (e.g., prevent unwanted pregnancies, etc.), (iii) inclusion of public facilities in ITH's delivery and QA ecosystem will improve service access, (iv) By addressing issues that hinder the demand for the services and commodities (e.g., age limit for NHIF), the uptake of these will increase, (v) county co-funding and participation in a RBF mechanism will incentivize GoK to sustainably improve the quality of public SRH services, (vi) the credibility and influence of the UN partners will positively impact the long-term prioritization of adolescent SRH and HIV care in national policies and the health agenda in Kenya.

2.2. Proposed intervention (max 4 pages, including graphic)

Description of the business model

The underlying programme of the JP, ITH, offers an integrated and comprehensive solution to providing adolescent centred SRH, HIV testing and treatment services to Kenyan adolescent girls. Through the Triggerise initiative, girls are connected to teenage-friendly services available at private clinics and pharmacies, as well as public facilities, where they can see ratings left by previous users. The platform offers incentives to reward girls for healthy behaviours, including taking up an SRH service or referring a friend to the platform. Providers are also incentivized for serving adolescents and are able to access platform data to monitor their performance and see feedback from adolescent users. A horizontal approach is taken to service provision where a diversity of demand generation and service delivery actors come together under the Triggerise platform to reach adolescent audiences and beneficiaries. The proposed JP revolves around 5 pillars:

d. *Demand generation & Behavioural nudges:* The JP focuses on deepening the reach of ITH by expanding the network of demand generation partners acting across different marketing channels. Notably, ITH will grow its ecosystem of specialized local Community Based Organizations (CBOs) and mobilizers to reach more marginalized groups as well as engage county government health workers to expand their reach to adolescents for NHIF enrolment.

Girls will be encouraged to engage in healthy behaviours via reminders and rewards to ensure sustained use of SRH and HIV services, and to incentivize girls to refer their friends to the platform. Girls will also be incentivized to enrol on the Triggerise platform (on mobile phones or a membership card) via rewards in the form of 'Tiko miles,' which are loyalty points that can be redeemed at local retailers. Overall, there are three main pathways to enrolment: (i) Assisted mobilization – relatively costly legacy enrolment method leveraging a network of community workers remunerated in the form of Tiko miles for each girl enrolled and active on the Triggerise platform; (ii) Self-enrolment – cost-effective user acquisition leveraging online channels and the fact that most urban target audiences have access to a mobile phone; (iii) Peer-to-peer enrolment – catalytic pathway building on a positive experience from existing users, whereby satisfied users are incentivized to share their positive experiences and refer friends to the platform.

e. *Delivery model transition and public capacity building:* The JP focuses specifically on the transitory phase for ITH, where it moves from delivering services only through private sector actors, initially funded solely by international donors, to building quality services within the public sector. To date, girls have been able to choose from a network of private service providers (incl. Marie Stopes, Population Services International and other private clinics and physical and online pharmacies), where they can order SRH and HIV products directly to their homes. All services accessed through the platform are free for girls, and they receive additional rewards for repeated use of services including counselling and HIV testing. Through the JP, ITH is launching a first pilot to include 300 public sector facilities, across 10 counties, onto the Triggerise platform. As Kenya operates a decentralized health system, the JP will work mostly at the county level, wherein the majority of decision-making power and budget allocation happens.

To ensure maximum added value to both adolescents themselves as well as the counties, the JP will support an expansion of the services offered by ITH to include HIV prevention and treatment services. This will likely improve the counties' interest in co-delivery and co-financing of the programme due to the expanded contribution towards their critical health outcomes targets, rather than the original narrower focus on mCPR expansion only. For adolescents, this also provides an improved offer with HIV services being often viewed

as somewhat less stigmatized than contraceptive services. The platform's ability to track individual user level data, allows for a unique opportunity to nudge adolescents who are HIV positive to comply with their antiretroviral treatment, and support them in their user journeys to achieve viral suppression.

In line with the WHO guideline on self-care interventions for health, the JP will build on Triggerise's work in the self-care space, where platform users increasingly take up SRH products (such as oral contraceptives and emergency contraception) and HIV self-tests from pharmacies (including online pharmacies), and products are delivered directly to girls after counselling from a nurse via the Triggerise call centre. This removes the need to interact with a physical health facility and eliminates fears around being seen by older members of the community or being judged by a health provider. This component of the programme is becoming increasingly valuable to the GoK and the county governments, as it offers a key route to removing pressure from public and private health providers and allows girls more power in handling their SRH needs independently, whilst still receiving support and guidance from the Triggerise platform and associated community mobilizers.

f. *Quality assurance:* The newly integrated providers will be trained to participate on the platform and serve girls with a high-quality service. The JP will provide UN normative guidance to guarantee quality and delivery alignment with national policy framework. The JP will also enable the introduction of a variable pay system for the service providers, based on quality indicators.

Feedback from users is used by ITH and its delivery partners for quality assurance of services across the services providers as well as for providers' accountability and continuous improvement of the platform and the services. Facilities and providers are also incentivized to provide competitive and high-quality services to adolescents.

g. *Advocacy, stakeholder engagement & evidence generation:* There is emerging evidence from ITH's midline and endline reviews that private sector providers feel an increased sense of accountability when able to access ratings data, and often look to improve the experience for adolescent clients in order to increase their ratings. They also feel incentivized to compete for adolescent clients, given the benefits of both service reimbursements and loyalty points for individual providers.

Focusing on metrics relevant for stakeholders as well as for government buy-in, the JP will evaluate whether the evidence generated through private sector providers (e.g., user ratings and facility rewards combination) provide similar results in the public sector. Ultimately the evidence and learnings generated will be used to influence national and county policies for adolescent SRH and HIV.

h. *Funding model transition*: The JP will be critical in negotiating co-financing of the interventions with both county health budgets for public sector delivery, and NHIF for private sector delivery. Progress has already been made in this area, wherein the 10 counties have agreed to co-finance the public integration component of the ITH programme, covering costs for service delivery including commodities and consumables purchasing, staff time, infrastructural costs in facilities, and additional targeted demand generation to adolescents.

The JP is also engaging with NHIF to ensure that private sector facilities are reimbursed for SRH services provided to 15 to 19-year-olds enrolled in NHIF. The JP expects to negotiate that this reimbursement payment should cover the costs of ITH also, given its value add to private facilities in terms of enrolling adolescents into NHIF, driving footfall towards clinics (and therefore additional NHIF insurance payments), and enabling clinic access to platform data for performance management and visibility over client feedback.

The JP will also play a key role in crowding in additional funders to support this transitory phase, where outcome funding will optimize the model, reduce its costs, and build trust among key public stakeholders. In parallel, traditional grant-making will be used to continue innovate on the model and explore optimal methods to reach marginalized groups, expanding the service offer available, and testing the model in new geographies.

During this transitory period, the programme has a major focus on achieving county and national government buy-in, as well as initiating quality assurance interventions for public sector facilities serving adolescents. To carry out the interventions, the JP has entered a co-creation process, integrating learnings from past and current incentives programmes to county facilities, with 10 counties namely Kakamega, Bungoma, Busia, Kisii, Nyamira, Migori, Homabay, Kisumu, Mombasa and Nairobi. So far, discussions have been held on the approach and metrics for quality assurance, accountability for providers, demand generation strategies and design of the facility incentives and cashflows for such.

In a context of low purchasing power, particularly among ITH's target users, and limited fiscal resources to fund public health services in Kenya, the JP acknowledges it will not be possible for the Triggerise platform to become fully financially self-sustainable in the foreseeable future. However, the JP seeks to build on the first tranche of outcome funding towards ITH, to further incentivize high impact performance and maximize efficiency through ongoing innovative RBF mechanisms, creating the necessary conditions for buy in from the county and national government in Kenya, paving the way for eventual full integration and funding of the model through the public sector.

Description of the proposed financial structure: Development Impact Bond (DIB)

Following a comparative analysis of possible traditional and innovative finance options to fund the JP we concluded that a DIB was the most suitable financing mechanism for this project *(for more information, see Annex 8).*

Being fully aware of the challenges involved in launching a DIB, we have designed a high-level structure that (i) will leverage the current First ASRH DIB's preparatory work, final evaluation and governance design, and learnings therefrom, (ii) facilitate investor fundraising thanks to blending short term output and longer term outcome payment metrics, (iii) facilitate the raising of outcome funding by allowing the participation of funders who – for statutory reasons or out of principle – will not pay for investor profits.

In parallel to the design of this JP, UNFPA ESARO has held consultations and tendered a consultancy to ensure UNFPA readiness to host and manage an outcomes fund. We expect that the convening power of UNFPA and the UN SDGPP at the UN RC, as well as the availability of a funding pooling facility will further facilitate donor fundraising and legal structuring for the DIB.

We envision the DIB as a catalytic step towards greater financial autonomy of ITH by encouraging funding diversification and government buy-in (*see section 2.1. Theory of Change*):

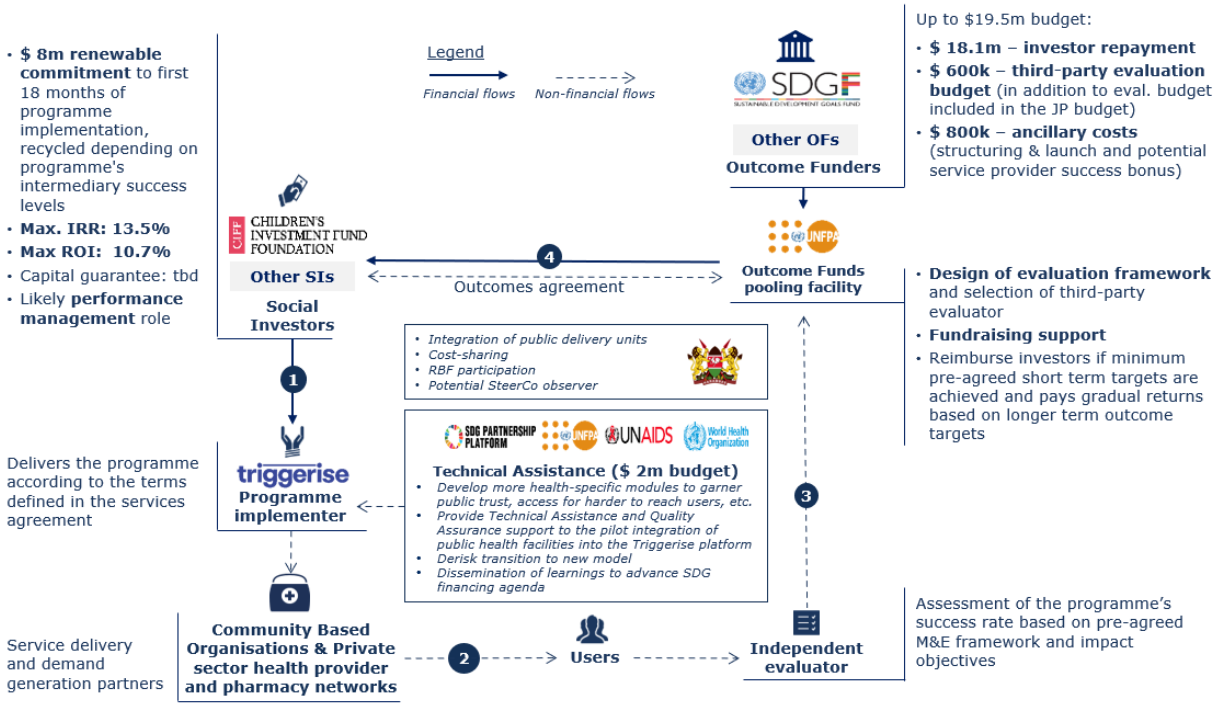
- We expect this second "ASRH Kenya DIB" to provide a pathway to setting up a follow-on "Development Social Impact Bond" anchored by GoK and potentially supported by the JP's partners – as an intermediary step to full government ownership and leadership of the programme. Separately, UNFPA's outcomes fund, exemplified by this first successful transaction, has the potential to replicate in other settings.
- The innovative and highly visible nature of DIBs will contribute to placing ASRH topics higher up on the national health agenda, unlocking national public funding as well as increasing commitment from the public health sector in general to deliver quality services to all girls.

Key additions of this DIB vs. the First ASRH DIB include *(for more information, see Annex 14):*

i. The longer timeline and bigger budget will enable tying payments to key JP components (e.g., HIV testing to treatment follow-through, measurement of visits and continuation/repeat visits under the constraint of a minimum proportion of public delivery) and the evaluation of key programme outcome metrics which were not previously evaluated, such as Adolescent Birth Rate (ABR) or continuation of mCPR.

j. GoK national and county government representatives will be invited to join the JP's steering committee. Public facilities will also take part of the new financing schemes through the participation in the results-based mechanism and cost-sharing activities *(see section 2.1. Theory of Change).*

The following high-level governance structure and payment terms for the "Second ASRH DIB" has been shared with potential investors and donors:



Final payment metrics, measurement methods and timelines will be defined during the structuring phase. For more information on the envisaged investment terms and cashflow schedules, see Annex 10. In addition to the key stakeholders and roles represented in the graph above, Annex 9 contains the complete stakeholders' table including envisioned roles beyond 2025+.

2.3 Leverage potential (max 1 page)

The JP's sector of intervention, target users and the lack of revenue-generating potential of the underlying intervention restricts its potential to attract return-seeking market capital, whether private or public. However, the JP is confident in its ability to mobilize resources from the increasing pool of private capital which is ready to invest in innovating development solutions with credible sustainability prospects – through grants, outcome funding, or concessional return seeking risk investment. The JP's initial conversations with private investors and donors have confirmed the attractiveness of a model that is designed to ensure sustainability through the leverage of digital means, a drive for cost efficiency and the creation of durable linkages with the country's public health response. DFI/IFI participation is much less likely at this stage of maturity (but likely in the future) due to the relatively small size of the JP, the political sensitivity of the issue being addressed, and the lack of direct quantifiable link with the country's economic growth.

This JP originated from the aligned objectives of the CIFF, the private founder of the ITH, and the UN SDGPP to work towards its long-term sustainability. CIFF's Impact Investment arm has confirmed its conditional intention to be an investor in the DIB, joined by the SDG Outcomes Investment Fund, a new fund jointly established by Bridges Outcomes and UBS Optimus Foundation, which has expressed a $3-5m investment interest (cf. letters in appendix). This JP also has support of Norway through Norad, which has demonstrated strong interest in its objectives and has requested further engagement with us. Following exposure by this JP of its strategy to overcome critical challenges in launching DIBs, Grand Challenges Canada appears to be willing to consider a role as investor or outcome funder; further engagement with GCC is planned.

Joint programme leverage (USD)	Status	Inception 2022	Y1 2023	Y2 2024	Y3 2025	Exit year 2026	JP
Joint Programme SDG Joint Fund ask		-	1,644,916	2,164,325	2,293,849	897,979	7,000,000
PUNO activities		-	667,023	667,023	667,023	-	2,001,070
Sustained advocacy and capacity building			214,892	214,892	214,892		644,676
Learning			129,292	129,292	129,292		387,875
JP coordination / GoK co-chaired SteerCo			107,000	107,000	107,000		321,000
Increased diversification of funding			32,156	32,156	32,156		96,469
DIB-specific activities ('Programme')			183,683	183,683	183,683		551,050
share of DIB external evaluation (incl. in PUNO budget above)			*53,500*	*107,000*	*107,000*	-	*267,500*
Outcome funding		-	977,893	1,497,302	1,626,826	897,979	4,998,930
Investor pre-financing			883,167	1,352,262	1,469,239	810,994	4,515,661
Investor premium		-	*94,517*	*144,720*	*157,239*	*86,793*	483,269
Indirect support costs		-	-	-	-	-	-
Total ITH SRH programme budget		4,900,000	5,330,992	6,348,321	6,672,676		18,351,988
Funding & Financing sources:							
Grants		4,900,000	-	-	-	-	4,900,000
CIFF bridging grant	committed	4,900,000	-	-	-	-	4,900,000
Investment financing		-	5,723,196	5,723,196	4,905,597		16,351,988
Conditional (CIFF & Bridges)	committed		4,574,399	4,574,399	4,301,866	-	13,450,663
Additional investor financing target	anticipated		1,148,797	1,148,797	603,731	-	2,901,326
o.w. Upfront financing commitment ask (to be recycled after 18 mths)			*5,723,196*	*3,270,398*	-	-	*8,993,594*
Government Co-financing		-	285,714	857,143	857,143	-	2,000,000
Counties	committed		221,494	664,483	664,483		1,550,460
Counties	anticipated		64,220	192,660	192,660		449,540
Outcome funding & Grants Budget		800,000	3,540,361	5,420,829	5,889,756	3,251,043	18,901,988
DIB Funding, Private sources	anticipated		1,180,120	1,806,943	1,963,252	1,083,681	6,033,996
DIB Funding, Public sources	anticipated		2,360,241	3,613,886	3,926,504	2,167,362	12,067,992
ow anticipated UNFPA/SDGFund Outcome Funding			*977,893*	*1,497,302*	*1,626,826*	*897,979*	*5,000,000*
DIB Structuring, fund-raising & legal setup costs		800,000					800,000
Balance to be raised		800,000	2,562,468	3,923,527	4,262,930	2,353,063	13,901,988
Investment and OF to be raised (excl. SDGFund ask & CIFF conditional commitment)			3,711,265	5,072,324	4,866,661	2,353,063	16,003,314

Leverage	2023	2024	2025	2026	JP
Private investment leverage	*3.5*	*2.6*	*2.1*	*0.0*	*2.3*
Additional outcome funding and investment leverage	*5.0*	*4.5*	*4.0*	*2.6*	*4.3*
Co-financing leverage ratio	*3.7*	*3.0*	*2.5*	*0.0*	*2.6*

2.4 Value add (max 0.5 page)

The engagement of the various UN agencies in the JP will bring significant added value to the intervention across three main dimensions:

- County level buy-in: the UNFPA and the UN SDGPP will leverage their existing relationship with county-level representatives to pilot the enrolment of public sector facilities onto the ITH platform and to strengthen the public sector response to ASRH *(see section 2.2, Proposed intervention).* As the manager of the outcomes Fund, the UNFPA will also play a key role in ensuring the successful transition towards GoK ownership and financing of the programme.
- Health services expansion: the unique sectorial expertise of UNAIDs and WHO will be utilized to i) strengthen public trust by developing health-specific modules ii) increase access for harder to reach users through the ITH platform and iii) ease county-level buy-in by widening the range of services offered to platform users.
- Funding diversification: the SDG Joint Fund's credibility and potential role as guarantor will be leveraged to attract new sources of private investments as well as to improve the fundraising potential of already committed investors. Similarly, by coordinating convening and outreach, the UN SDGPP will be a key facilitator to help JP partners to leverage additional funding for the programme.

In addition to the added value of individual UN agencies, the JP partners aim to leverage UN's convening role, credibility, technical firepower and influence to ensure the long-term prioritization of adolescent SRH and HIV care within policies and health agendas in Kenya and across the region. The UN's role as a public trust guarantor will also be important to ensure successful engagement with the GoK on potential programme funding.

2.5 Innovative nature (max 0.5 page)

This JP offers an innovative solution to building government buy-in and financing for high quality adolescent SRH and HIV services. The JP has laid the groundwork with Kenyan county governments to develop co-financing and co-delivery arrangements, wherein the counties will share costs of the delivery of the ITH model in public health facilities. With the JP, public facilities will also have a direct role in financing demand generation among adolescents and delivering SRH and HIV services.

In addition, the Triggerise platform that collects real-time data, inspires service providers to become responsive in their service delivery to this audience group by integrating direct feedback received on the platform. Besides the platform approach, the JP offers a unique opportunity for a range of private and public sector actors to work together towards a common goal. As Kenya enters a transformational phase of its health sector development, through expansion of UHC and the NHIF scheme, the JP will play a key role both in enrolling young people onto NHIF, and in advocacy efforts to direct GoK funds towards quality adolescent SRH and HIV care.

The DIB model itself is a unique instrument that allows to attract private and public investment into an otherwise underfunded and under-prioritized sector, leaving room to tailor the deal's terms to stakeholders' preferences while achieving impact. The DIB is not only one of the first DIBs focused on ASRH globally, but it will also catalyse the creation of the first UNFPA-managed outcome fund whereby UNFPA will leverage its sectorial expertise and UN-funds pooling facilities. By engaging in the DIB, the UN will be more fit-for-purpose to manage funds for impact and replicate other relevant projects, in line with the UN Reform agenda on the transition from SDG Funding to Financing. The DIB will also enable the UN to shift risks from its own budget to that of private investors.

2.6 Results (max 2 pages+graphic)

The JP targeted outputs and outcomes are structured in relation to the long-term objective of increased empowerment of SRH and HIV service users, which is aligned with the prioritized SDG targets. The programme will work with a set of outputs used as performance management indicators (i.e., measure of efforts of activities conducted) that will be tracked through the existing systems such as (i) via the Triggerise platform in real time, (ii) National reporting platform for the public sector (Kenya Health Information System) or (iii) via a survey among the programme's target users and key ecosystem players.

The outputs will contribute to the achievement of the programme's primary outcomes (See table below). Given that the programme targets 15-19-year-old girls, these outcomes materialize in a 1- to 3-year time horizon. The implementation of the DIB in collaboration with the public sector will directly support the achievement of SDG 3, 5 and 17, while the evaluation will specifically monitor progress on SDG 3, with more emphasis on target 3.3 and 3.7 of ending AIDS epidemic and universal access to SRH services (incl. family planning services and integration of SRH into national strategies and programmes) respectively. Achieving the programme's primary outcome goals is a precondition for the generation of the long-term outcomes specified in the ToC.

Platform	Output	Primary outcomes
Triggerise platform	No of girls who access SRH and HIV services via Triggerise platform No. of adolescent girls receiving modern contraceptives. No of public facilities, clinics/pharmacies enrolled on Triggerise platform No of girls rating their services Medium provider rating No of public facilities and clinics that provide services via Triggerise platform that have received clinical quality audits	Contraceptive prevalence rate Couple years of protection (CYP) No of estimated pregnancies averted No of estimated abortions averted % of adolescents 15–19 years who know their HIV status No of new HIV infections averted No of AIDS-related death averted
Leverage of public sector platform (KHIS) for comparison with Triggerise data	No of adolescents aged 15–19 years tested for HIV No of adolescent 15–19 years newly diagnosed linked to HIV care and treatment No of adolescent 15–19 years currently on ART	
Surveys	% of girls confident in using a form of modern contraception % of girls who believe that girls like them use contraception % of girls who recommend any modern contraceptive to other people % of girls who demonstrate comprehensive knowledge on SRH Knowledge of HIV prevention methods/interventions among the adolescents	

<u>Short term outcomes/outputs (1–4 years)</u>

Since inception in 2017, ITH has demonstrated success in achieving quality outputs by serving large volumes of girls with reproductive health services and HIV self-tests, as well as securing financing. The output, number of (new and repeat) ASRH service users, is tracked through the Triggerise platform, where results can be monitored on a daily basis. The CPR outcome is measured with a counterfactual method in the First ASRH DIB. Similar modality will be used during implementation with the inclusion of additional HIV services indicators. These

indicators are expected to start generating positive impact during or within one year of the programme's implementation.

Critical pathways to the public sector are piloted, including strengthening the public sector response to ASRH and HIV services, and positioning for increased public spending towards ASRH and HIV services. With increased funding for the intervention, ITH goes 'deeper' in communities where it works already to better serve harder-to-reach adolescents, and pilots an expanded service package to support girls across key moments in their adolescent lives: menstruating, becoming sexually active, having their first children, support for employment and responding to crises including sexual and gender-based violence, and mental health issues.

Midterm outcomes/outputs (5–10 years)

With strong impact evidence from the interventions supported by the First ASRH DIB and the JP, alongside proven public sector strengthening interventions, and some public purchasing of ITH services, the JP expects significant buy-in and institutionalization by GoK and other funding partners (such as bilateral/international donors) to support ASRH programmes. ITH has a broadened service offering to allow for an improved value proposition in relation to GoK's family planning targets as outlined in Annex 15. In addition, the programme in collaboration with the public facilities will target HIV indicators as outlined below.

Strategy	Indicator
Reduce new HIV infections among adolescents	• Comprehensive knowledge about HIV among the adolescents • Uptake of HIV combination prevention services among the adolescents
Strengthen provision of adolescent friendly HIV care and treatment services	• Referral of HIV positive adolescents to care and treatment services • 95 95 95 treatment targets among the adolescents • Adolescent adherence and retention rates

Long-term outcomes/outputs (10+ years)

A major body of evidence will have emerged from the work of ITH and the JP emphasizing how the power of improved ASRH and HIV outcomes in Kenya propels long-term impact in terms of increased empowerment of adolescent girls, alongside significant health services savings as a direct result of reduced teenage pregnancies and new HIV infections. The proposed intervention creates solid foundations to catalyse change across populations and generations in Kenya, contributing to the prosperity of the country by creating a momentum for the cause and attracting other actors.

Leaving no girl behind

Triggerise and JP uses youth-centred design principles so that the diverse needs of different groups of adolescents are at the core of programme design and delivery.

2.7 Gender and human rights plan (max 1 page)

The JP will contribute to positive gender and human rights outcomes by expanding options for girls to access SRH and HIV services and by improving their autonomy to choose where to access services through a digital-based platform, which gives them ownership of their healthcare decisions and enables them rate health services. This shifts girls' role from that of a neglected recipient to a powerful consumer. In addition, this programme recognizes the heterogeneous nature of adolescent girls and is responsive to their preferences.

By tackling some of the drivers of teenage pregnancy and adolescent HIV (e.g., lack of access to quality services) and reducing its disproportionate effects on girls (e.g., school dropout, diminished economic opportunities), the JP will be contributing to ending gender inequalities.

List of marginalized and vulnerable groups	Dedicated Outcome	Dedicated Output
Women and girls	Yes	Yes
Children	Yes	Yes
Youth	Yes	Yes
Persons with disabilities	Yes	Yes
Older persons	No	No
Minorities (incl. ethnic, religious, linguistic…)	No	No
Indigenous peoples	No	No
Persons of African Descent (when understood as separate from minorities)	No	No
Migrants	No	No
Refugees & asylum seekers	No	No
Internally displaced persons	No	No
Stateless persons	No	No
Persons deprived of their liberty	No	No
Peasants and rural workers	No	No
Human rights defenders (incl. NGOs, journalists, union leaders, whistle-blowers…)	No	No
LGBTI persons (sexual orientation and gender identity)	No	No
Persons affected by (HIV/AIDS, leprosy…)	Yes	Yes
Persons with albinism	No	No
Victims or relatives of victims of enforced disappearances	No	No
Victims of (slavery, torture, trafficking, sexual exploitation and abuse…)	No	No
Other groups: (please specify which)	No	No

2.8 Progress (max 1 page)

The ITH model is in its fourth year of operations in Kenya, with strong results: over 750,000 girls have signed up to the digital platform, which is connected to a network of just under 300 clinics and pharmacies, and 540,000 girls have taken up SRH and HIV services. A rich body of data and learnings has been generated, enabling continuous optimization of performance and cost reduction. Now when ITH has proven its concept, it is moving into a transitory phase, wherein it requires catalytic support from the JP and its networks, to capitalize on the government support it has generated, and integrate with the government through financing and co-delivery of the ITH model.

The UN SDGPP has been engaging with both CIFF and FCDO since the inception of the design phase of the First ASRH DIB in 2019, providing technical inputs to KOIS – the design intermediary contracted by CIFF – and has facilitated access to its networks for further inputs from partners into the design process. An in-depth evaluation of feasible outcome metrics relevant for ITH's Theory of Change and acceptable for investors was conducted by KOIS.

The JP partners intend to leverage the significant work that went into the design of the First ASRH DIB to significantly reduce ancillary costs of the 2nd tranche. Additionally, the endline evaluation conducted by the independent evaluator for the FDCO DIB, Hera, can serve as a baseline for this second tranche of the bond, allowing evaluation savings. Given that DIBs remain an underutilized model in LMICs, lessons learnt from the existing DIB will be central to the design and delivery of the second tranche, particularly in terms of realistic outcome targets, payment terms, and how to utilize support from investor partners.

The JP Partners have worked in a consortium for 18 months to design and build support for ITH's 'transition to sustainability' phase. This has included strategic design work on government integration, and the sustainability of the model, as well as an analysis of similar RBF models, building in key learnings from other RBF programmes. A co-creation workshop and subsequent 1:1 meetings with the 10 counties were conducted to build the solution in line with county needs and priorities. Key outcomes from this county engagement include agreement on delivery of the ITH model through 300 public sector clinics, co-financing of the intervention and MOUs for each county.

Once the 'transition to sustainability' phase was designed, a comparative analysis of financing models was conducted. Following this analysis, a DIB was selected as the most suitable blended financing mechanism given the project's risks and the JP's objectives *(for more information, see Annex 8)*.

The JP has since been executing its fundraising strategy, materialized by a shared database of traditional grantor, outcome funder and investor targets – focusing on private and public organizations with a focus on girls empowerment and/or healthcare or a known interest for financial innovation – and assigned priorities and opportunities based on relationship strengths within the SDGPP, UNFPA, CIFF, KOIS and Triggerise teams. Pitch calls and follow-up engagement have been conducted with Equity Group Holdings, Grand Challenges Canada (GCC), CIFF's impact investment team, the UBS Optimus-Bridges Outcomes Investment Fund, and Norway (through Norad).

Following sharing of high-level indicative investment terms and engagement by the JP (*see section 2.2, above, and Annex. 10)*, CIFF's impact investment team and the SDG Outcomes Investment Fund have issued letters to confirm their conditional interest to be investors, up to a combined amount of $ 8m, recyclable once, after 18 months. Both investors have proposed to provide design support and performance management for the DIB.

Norway has expressed support for this initiative and suggested follow-up engagement at board level. GCC is considering a role as investor or outcome funder *(see 2.3 Leverage)*.

2.9 Sustainability (max 0.5 page)

The JP will be catalytic in transitioning the ITH model to sustainability through integrating high-quality public sector care within the ITH ecosystem, alongside increasing public and private sector financing for ASRH and HIV care through a range of results-based financing mechanisms, designed to optimize performance and reduce programme costs.

The JP's vision for sustainability beyond the programme intervention period includes the following:

- *High-quality public-sector adolescent SRH and HIV care* – the JP's integration of 300 public clinics onto the ITH ecosystem will build key evidence for improving the public sector response to ASRH and HIV care, ready for replication in the additional counties
- *County governments and NHIF are key long-term financing stakeholders* – as Kenya moves towards universal health coverage, the counties will increase their spend on ASRH and HIV care, alongside NHIF reimbursements to private facilities, covering the costs of services taken by adolescents in private clinics.
- *Decreased costs of ASRH and HIV interventions* – the ITH intervention will utilize public sector cost sharing, economies of scale and strengthened technology to further reduce its costs from $34 to $21 per user by 2026;
- *Triggerise as technical assistance and technology partner* – Triggerise and UN teams will reduce their role in implementation, and focus on quality assurance and technical assistance with public and private sector facilities

This will be achieved during the lifetime of the 3-year JP. Notably, the major shift towards public sector integration of the ITH will allow Triggerise to transition to focus on quality control, incentives design and accountability initiatives to motivate improved service delivery among public facilities and providers. UN partners will utilize their convening power both to gather compelling evidence on what works in reaching adolescents, ready for replication beyond the 10 implementation counties, as well as to advocate for increased commitment and financing towards adolescent SRH and HIV quality care in line with UHC goals via NHIF and county budget allocations.

2.10 Replicability (max 0.5 page)

The proposed DIB model is innovative and readily replicable not only as a financing mechanism for SRH interventions but also as a mechanism that can be used to finance other social impact causes not only in Kenya but in other countries as well. The fusing of Government and private sector financing through an innovative results-based framework ensures an efficient use of development funds with adequate incentives for all stakeholders. The structure also ensures that effectiveness and efficiency are monitored and transparently communicated.

To enhance the prospects of replicability, the key stakeholders and promoters of the Second ASRH DIB bring on board broad interests and expertise. ITH's cost effectiveness, expert implementing steering committee and innovative nature allow for prime positioning with investors and outcome funders, for expansion of the DIB. Further, replication of the Second ASRH DIB as an instrument mechanism opens the possibility of scaling up the number of counties of focus thereby potentially availing ASRH services to a wider section of the Kenyan population. In addition, there is a great possibility to scale up and replicate the concept to other countries with similar contexts to Kenya. Through the DIB, it is anticipated that the innovative integration of private and public finance will provide a pathway for the replication of innovative outcome funds for social good. Future outcome funds could leverage the learnings of this solution and replicate the model across developing countries.

3. Programme implementation

3.1 Governance and implementation arrangements (max 1 page)

The JP will be governed at two levels; the Steering Committee and the Technical Committee. The two-tiered governance structure is informed by the need to incorporate all the key participants in effective governance of the DIB.

The apex tier of the Steering Committee (SteerCo) that will be the overarching governance body of the programme and will provide strategic guidance and oversight. The SteerCo membership will also support advocacy, and resource mobilization for the programme. Quarterly meetings are envisioned for the SteerCo with matters relating to the JP being a standing agenda item of the meeting.

The operational level of governance will be the Technical Committee which will be responsible for overall programme management and coordination including resource mobilization for the programme.

The Technical Committee will, where necessary, establish subcommittees to deal with specific aspects of the JP and is also expected to meet at least on a quarterly basis with monthly meetings anticipated in the first year. Annual field monitoring across project sites will be carried out by the Technical Committee.

It is expected that a close working relationship between the two tiers will arise and seamless information flow between the two tiers will be occurring through both formal and informal channels.

	Programme Governance				Membership
Steering Committee (SteerCo)	Strategic Guidance	Oversight	Advocacy	Resource Mobilization	Cabinet Secretary for Health (Co-Chair); Chairman of Health at the Council of governors (Co-Chair); UNH6 Heads of Agencies, as well as from UNIDO and UNIOPS

	Programme Management and coordination			Membership
Technical Committee	Service Delivery	Strategy Execution	Resource Mobilization	Technical staff from: Joint programme Partners; Government partners (MOH, NCPD, National Treasury, Council of Governors); and target implementation counties

3.2 Partnerships and stakeholder engagement (max 1 page)

Stakeholder name	Role of stakeholder in structure	Level of engagement/support to date
Ministry of Health	The Ministry of Health will provide strategic and technical Leadership through participation in the JP Steering and Technical committee	The Ministry of Health has been engaged in various activities in support of the ITH programme since its launch in 2017.
National Treasury	The National Treasury will provide technical support in matters relating to funds transfers to counties	The National Treasury has been sensitized about the programme and has expressed its support for the programme as noted in the letter of support provided as an annex.
Council of Governors	The Council of Governors will provide programme stewardship and ensure cross learning among counties	The Chairman of the CoG Health Committee is currently a co-chair of the SDGPP .
County governments (10)	The county governments will implement the programme	The Pilot county governments have been engaged with ITH from its programme inception in 2017
NCPD	Provide implementation support for the JP including advocacy	The NCPD has been engaged extensively in programme design.
CIFF	CIFF will be a member of the SteerCo and will provide investor and programme management.	CIFF have funded and managed ITH from its inception and will act as the anchor investor.
FCDO	FCDO will be an Outcome Funder and will serve the SteerCo as a member.	FCDO have participated in the proposal outreach activities and contributes to its structuring.
National Advisory Board for Impact investment in Kenya (NAB)	The NAB will convene the impact financing ecosystem in Kenya with a view to support the JP in its SDG financing policy efforts.	Initial Second ASRH DIB sensitization of the NAB has already taken place
Africa Venture Philanthropy Association (AVPA)	The AVPA will be a catalyst for future funding, through its deal-sharing platform and marketing of the DIB to its membership and networks.	The JP has pitched the Second ASRH DIB to AVPA membership and is following up on leads.
SDGPP membership	SDGPP partners will be mobilized to facilitate the scale-up of the First ASRH DIB through offering of their expertise, voice, networks and possibly funding and financing.	Through its network, the SDGPP has identified potential outcome funders and active outreach has commenced.
Global Joint SDG fund donors	Provide strategic oversight to the Programme	The UN maintains strong partnerships with all Joint SDG Fund donors present in Kenya

3.3 Monitoring, reporting, and evaluation

Reporting on the Joint SDG Fund will be results-oriented, and evidence-based. Each PUNO will provide the Convening/Lead Agent with the following narrative reports prepared in accordance with instructions and templates developed by the Joint SDG Fund Secretariat:

- *Annual narrative progress reports*, to be provided no later than. one (1) month (31 January) after the end of the calendar year, and must include the result matrix, updated risk log, and anticipated expenditures and results for the next 12-month funding period;
- *Midterm progress review report* to be submitted halfway through the implementation of the JP[2]; and
- *Final consolidated narrative report*, after the completion of the JP, to be provided no later than two (2) months after the operational closure of the activities of the JP.

The Convening/Lead Agent will compile the narrative reports of PUNOs and submit a consolidated report to the Joint SDG Fund Secretariat, through the Resident Coordinator.

The UN Resident Coordinator will be required to monitor the implementation of the JP, with the involvement of Joint SDG Fund Secretariat to which it shall submit data and information when requested. As a minimum, JPs will prepare, and submit to the Joint SDG Fund Secretariat, 6-month monitoring updates. Additional insights (such as policy papers, value for money analysis, case studies, infographics, blogs) might need to be provided, per request of the Joint SDG Fund Secretariat. Joint programme will allocate resources for monitoring and evaluation in the budget.

Data for all indicators of the results framework which will be shared with the Fund Secretariat on a regular basis, in order to allow the Fund Secretariat to aggregate results at the global level and integrate findings into reporting on progress of the Joint SDG Fund.

PUNOs will be required to include information on complementary funding received from other sources (both UN cost sharing, and external sources of funding) for the activities supported by the Fund, including in kind contributions and/or South-South Cooperation initiatives, in the reporting done throughout the year.

PUNOs at Headquarters level shall provide the Administrative Agent with the following statements and reports prepared in accordance with its accounting and reporting procedures, consolidate the financial reports, as follows:

- Annual financial reports as of 31st December each year with respect to the funds disbursed to it from the Joint SDG Fund Account, to be provided no later than four months after the end of the applicable reporting period; and
- A final financial report, after the completion of the activities financed by the Joint SDG Fund and including the final year of the activities, to be provided no later than 30 April of the year following the operational closing of the project activities.

In addition, regular updates on financial delivery might need to be provided, per request of the Fund Secretariat.

After completion of a JP, a final, *independent and gender-responsive*[3] *evaluation* will be organized by the Resident Coordinator. The cost needs to be budgeted, and in case there are

[2] This will be the basis for release of funding for the second year of implementation.

[3] How to manage a gender responsive evaluation, Evaluation handbook, UN Women, 2015

no remaining funds at the end of the JP, it will be the responsibility of PUNOs to pay for the final, independent evaluation from their own resources.

The JP will be subjected to a joint final independent evaluation. It will be managed jointly by PUNOs as per established process for independent evaluations, including the use of a joint evaluation steering group and dedicated evaluation managers not involved in the implementation of the JP. The evaluations will follow the United Nations Evaluation Group's (UNEG) Norms and Standards for Evaluation in the UN System, using the guidance on Joint Evaluation and relevant UNDG guidance on evaluations. The management and implementation of the joint evaluation will have due regard to the evaluation policies of PUNOs to ensure the requirements of those policies are met and the evaluation is conducted with use of appropriate guidance from PUNOs on joint evaluation. The evaluation process will be participative and will involve all relevant programme's stakeholders and partners. Evaluation results will be disseminated among government, development partners, civil society, and other stakeholders. A joint management response will be produced upon completion of the evaluation process and made publicly available on the evaluation platforms, or similar, of PUNOs.

3.4 Accountability, financial management, and public disclosure

The JP will be using a pass-through fund management modality where UNDP Multi-Partner Trust Fund Office will act as the Administrative Agent (AA) under which the funds will be channelled for the JP. Each Participating UN Organization receiving funds through the pass-through has signed a standard Memorandum of Understanding with the AA.

Each Participating UN Organization (PUNO) shall assume full programmatic and financial accountability for the funds disbursed to it by the Administrative Agent of the Joint SDG Fund (Multi-Partner Trust Fund Office). Such funds will be administered by each UN Agency, Fund, and Programme in accordance with its own regulations, rules, directives and procedures. Each PUNO shall establish a separate ledger account for the receipt and administration of the funds disbursed to it by the Administrative Agent.

Indirect costs of the Participating Organizations recovered through programme support costs will be 7%. All other costs incurred by each PUNO in carrying out the activities for which it is responsible under the Fund will be recovered as direct costs.

Funding by the Joint SDG Fund will be provided on an annual basis, upon successful performance of the JP.

Procedures on financial transfers, extensions, financial and operational closure, and related administrative issues are stipulated in the Operational Guidance of the Joint SDG Fund.

PUNOs and partners must comply with Joint SDG Fund brand guidelines, which includes information on donor visibility requirements.

Each PUNO will take appropriate measures to publicize the Joint SDG Fund and give due credit to the other PUNOs. All related publicity material, official notices, reports and publications, provided to the press or Fund beneficiaries, will acknowledge the role of the host Government, donors, PUNOs, the Administrative Agent, and any other relevant entities. In particular, the Administrative Agent will include and ensure due recognition of the role of each Participating Organization and partners in all external communications related to the Joint SDG Fund.

3.5 Legal context

The following agreements form the legal basis for the relationships between the Government and each of the UN organizations participating in this JP.

Agency name: UNFPA

Agreement title: Standard Basic Assistance Agreement

Agreement date: 4 January 2004

Agency name: UNAIDS

Agreement title: Standard Basic Assistance Agreement

Agreement date: 4 March 2010

Agency name: WHO

Agreement title: Standard Basic Assistance Agreement

Agreement date:

D. ANNEXES OF THE JOINT PROGRAMME TEMPLATE

Annex 1. List of related initiatives

Name of initiative/project	Key expected results	Links to the joint programme	Current status	Lead organization	Other partners	Budget and funding source	Contract person (name and email)
The UN Joint Programme on HIV/AIDS	1. All children, women and men living with HIV know their status, are linked to and sustained on treatment. 2. Young people, key and priority populations are empowered to protect themselves from HIV and all children, women and men have access to combination prevention services.	The programme focuses on empowering young people to protect themselves from HIV and increasing access to HIV testing services by young people which are the ambitions of the JP. The JP will leverage on the experiences and lessons of this existing programme to promote access to HIV prevention information and services among adolescents.	The programme is on the second year of implementation	UNAIDS	UNFPA UNICEF UNESCOILO WFP UNDP UNWOMEN UNHCR UNODC	$600,000 per year	Dr. Medhin Tsehaiu, Country Director, UNAIDS Tsehaium@unaids.org
The UN H6 Joint programme on Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH)	To contribute towards reduction in preventable maternal, newborn and child deaths in six high burden counties by 2020. The key expected results are to increase access and improve quality of RMNCAH services, stimulate demand for services and strengthen county capacity to deliver on integrated quality RMNCAH, HIV and GBV services.	The UN H6 JP on RMNCAH ended in 2020. The JP will, however, leverage on lessons learnt and the enabling environment for RMNCAH incl. ASRH interventions created by the programme nationally and in the six high burden counties, s	The programme ended in 2020 with few add-ons in 2021	UNFPA	UNICEF, WHO, UNAIDS, and UN Women	6.9 million USD (~40 million DKK) The Royal Danish Embassy of Denmark in Kenya	UNFPA Kenya Representative, Ademola Olajide, Olajide@unfpa.org

UN SDGPP	The SDGPP convenes and connects leadership from Government, development partners, private sector, philanthropy, civil society, and academia to create SDG accelerator windows to catalyse SDG partnerships, financing and innovations in alignment with Government development priorities.	The UN SDGPP has over the last 3 years facilitated research, build capacities, established diverse partnerships and supported testing and scaling of a variety of innovate SDG financing instruments, incl DIBs. The JP will leverage on these capacities and networks.	The SDGPP SDG3 Window is in its third year of implementation	UN RCO lead coordination	WHO, UNAIDS, UNICEF, UNIDO, UNDP, UNOPS, FAO, IFAD, WFP	Approximately $9 million funding and in-kind support from a variety of funders and investors	Arif Neky, SDGPP Lead for Health, Arif.neky @one.un.org

Annex 2. Results Framework

2.1. Targets for Joint SDG Fund Results Framework

Joint SDG Fund Outcome 2: Additional financing leveraged to accelerate SDG achievement

Indicators	Targets			
	2022	**2023**	**2024**	**2025**
2.1: Ratio of financing for integrated multi-sectoral solutions leveraged in terms of scope[4]				
Public financing		$ 285,714	$ 857,143	857,143
Ratio of public financing to SDG Fund budget		0.17	0.40	0.37
Private financing	$ 4,900,000	$ 5,723,196	$ 5,723,196	$ 4,905,597
Ratio of private financing to SDG Fund budget	N/A	3.48	2.64	2.14
SDG 3: Ensure healthy lives and promote well-being for all at all ages				
By 2030, reduce global maternal mortality ratio (MMR) to less than 70/100,000 live births	355	320	288	260
By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, waterborne diseases, and other communicable diseases.				
By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.	58	59	60	61
Goal 5: Achieve gender equality and empower all women and girls				

[4]Additional resources mobilized for other/additional sector/s or through new sources/means

By 2030, ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.				
Goal 17: Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development				
By 2030, mobilize additional financial resources for developing countries from multiple sources.				
By 2030, encourage and promote effective public, public-private and civil society partnerships, building on the experience and resourcing strategies of partnerships.				
2.2: Ratio of financing for integrated multi-sectoral solutions leveraged in terms of scale[5]				

Joint SDG Fund Operational Performance Indicators

(do not change or add – this is for information only so that teams know what they will be assessed against).

- Level of coherence of UN in implementing programme country[6]
- Reduced transaction costs for the participating UN agencies in interaction with national/regional and local authorities and/or public entities compared to other JPs in the country in question.
- Annual % of financial delivery
- Joint programme operationally closed within original end date
- Joint programme financially closed 18 months after their operational closure
- Joint programme facilitated engagement with diverse stakeholders (e.g. parliamentarians, civil society, IFIs, bilateral/multilateral actor, private sector)
- Joint programme included addressing inequalities (QCPR) and the principle of 'Leaving No One Behind'
- Joint programme featured gender results at the outcome level
- Joint programme undertook or draw upon relevant human rights analysis, and have developed or implemented a strategy to address human rights issues

[5]Additional resources mobilized for the same multi-sectoral solution.

[6] Annual survey will provide qualitative information towards this indicator.

- Joint programme planned for and can demonstrate positive results/effects for youth
- Joint programme considered the needs of persons with disabilities
- Joint programme made use of risk analysis in programme planning
- Joint programme conducted do-no-harm/due diligence and were designed to take into consideration opportunities in the areas of the environment and climate change

2.2. Joint programme Results framework

Complete the table below – add rows as needed. Where relevant/available, please include sex disaggregated data.

Result/Indicators	Baseline	2023 Target	2024 Target	2025 Target	Means of Verification	Responsible partner
Outcome 1: Reduction in adolescent birth rate with increased contraceptive prevalence rates among adolescent girls						
Number of unwanted pregnancies averted		64,400	71,900	81,000	Impact2 Calculator	Triggerise
Number of unsafe abortions averted		21,850	24,500	27,500	Impact2 Calculator	Triggerise
Output 1.1: Increased and sustained uptake of ASRH services by adolescent girls						
Number of adolescents served with SRH services (FP)		120,000	134,000	151,000	Triggerise platform data	Triggerise
Number of adolescent SRH services provided.		158,000	175,500	198,000	Triggerise platform routine data	Triggerise
Number of adolescents on short acting methods.		76,250	85,000	98,950	Triggerise platform routine data	Triggerise
Number of adolescents on LARC		43,750	49,000	52,050	Triggerise platform routine data	Triggerise
Output 2.2: Improved attractiveness of ASRH and HIV services across public and private facilities						

Proportion of public and private health facilities providing quality adolescent-friendly services in line with national standards	TBD	70%	90%	95%	Programme data	Triggerise
% of providers receiving minimum rating score of 2 out of 5		1%	1%	1%	Triggerise platform routine data	Triggerise
Number of adolescents that provide feedback on their service		56,700	63,420	71,460	Triggerise platform routine data	Triggerise
Outcome 2: Reduction in new HIV infections and AIDS related deaths among adolescent girls						
% reduction in new HIV infections			35%		HIV estimates report	UNAIDS
% reduction in AIDS related deaths				25% (To be assessed in 2026 report)	HIV estimates report	UNAIDS
Output 2.1 Increased HIV testing and treatment access for adolescent girls						
Number of adolescents served with HIV tests		15,500	17,300	19,500	Triggerise platform routine data	Triggerise
Number of HIV tests provided		20,200	22,500	25,300	Triggerise platform routine data	Triggerise UNAIDS
% of positive adolescents followed though to treatment (ART)	93.4% (KHIS 2020)	94%	95%	97%	Programme data	Triggerise UNAIDS
Outcome 3: Increased agency of adolescent girls to exercise their sexual and reproductive health and rights						

% of adolescent girls demonstrating the right attitudes/intentions towards SRH and HIV service uptake		70%	80%	90%	Triggerise call centre surveys	Triggerise
Outcome 4: Increased public sector capacity to participate in user driven solutions and to provide quality ASRH and HIV services						
Number of public institutions (national and county level) engaged to implement quality user centred ASRH and HIV service delivery programmes		13 (10 counties, Council of Governors, NHIF, MOH, NASCOP)	13 (10 counties, Council of Governors, NHIF, MOH, NASCOP)	13 (10 counties, Council of Governors, NHIF, MOH, NASCOP)	Programme data	UNFPA, UNAIDS,WHO, SDGPP
Output 4.1:Counties are equipped to deliver quality ASRH and HIV services in line with national and global standards						
Number of health facilities in target counties supplied with quality enhancement tools on ASRH and HIV service delivery (Job-Aids, patient literacy materials, support supervision tools, quality checklist for Adolescent and Youth Friendly Services(AYFS)		100	300	300	Programme data	UNFPA and UNAIDS
Number of health care workers in target counties trained on provision of Adolescent friendly service provision, new HTS guidelines, differentiated service delivery, and revised ART treatment guideline		500	500		Programme data	UNFPA and UNAIDS

Output 4.2: Evidence on public sector integration, Quality Improvement and innovative financing through Development Impact Bonds generated, documented and disseminated						
Number of studies conducted and disseminated to inform advocacy and practice on innovative financing and delivery of quality ASRH and HIV services in the public sector		1	1	1	Studies	WHO
Outcome 5 - Diversified available pool of private and public funding for ASRH and HIV services						
Investment commitments secured from private sources (mainly)	$8Mx2				Programme data	UNFPA SDGPP
Grant and outcome funding commitments secured from private and public sources	$5M	$9.2M			Programme data	UNFPA SDGPP

Annex 3. Gender marker matrix

Indicator		**Score**	**Findings and Explanation**	**Evidence or Means of Verification**
N°	*Formulation*			

1.1	Context analysis integrate gender analysis incorporating use of sex disaggregated data	**3**	The programme primarily targets young adolescent girls. Targeted gender analysis of those furthest left behind	Outlined programme strategies and indicators.
1.2	Gender Equality mainstreamed in proposed outputs	**3**	The programme strategies and indicators target SDG 5 priority on universal access to SRHR as well as the use of technology	Outlined Programme strategies and indicators
1.3	Programme output indicators measure changes on gender equality	**3**	The programme indicators measure changes over time on access to comprehensive services for adolescent girls	Outlined programme strategies and indicators
2.1	PUNO collaborate and engage with Government on gender equality and the empowerment of women	**2**	The programme engages with the county department of gender which contributes to GEWE reporting	Partnership and stakeholder engagement.
2.2	PUNO collaborate and engage with women's/gender equality CSOs	**2**	PUNO engages with GEWE CSOs at the grassroots level	
3.1	Program proposes a gender-responsive budget	**2**	Whereas the programme primarily targets young adolescent girls,dedicated budgets for health systems strengthening will benefit both boys and girls	Annual budgets
Total scoring		**2.5**		

Annex 4. Budget and Work Plan

4.1 Budget per UNSDG categories

UNDG BUDGET CATEGORIES	PUNO UNFPA		PUNO UNAIDS		PUNO WHO		TOTAL	
	Joint SDG Fund (USD)	PUNO Contribution (USD)	Joint SDG Fund (USD)	PUNO Contribution (USD)	Joint SDG Fund (USD)	PUNO Contribution (USD)	**Joint SDG Fund (USD)**	**PUNO Contribution (USD)**
1. Staff and other personnel	195,000	175,000	165,000	220,000	105,000	105,000	465,000	500,000
2. Supplies, Commodities, Materials	28,000		29,383		12,875		70,258	
3. Equipment, Vehicles, and Furniture (including Depreciation)	-		-		-		-	
4. Contractual services	308,000		323,212		141,625		772,837	
5.Travel	84,000		88,149		38,625		210,774	
6. Transfers and Grants to Counterparts (DIB-service delivery)	4,671,897		-		-		4,671,897	
7. General Operating and other Direct Costs	140,000		146,915		64,375		351,290	
Total Direct Costs	**5,426,897**		**752,659**		**362,500**		**6,542,056**	
8. Indirect Support Costs (precisely 7%, except WFP)	**379,883**		**52,686**		**25,375**		**457,944**	
TOTAL Costs	**5,806,780**	**175,000**	**805,345**	**220,000**	**387,875**	**105,000**	**7,000,000**	**500,000**

The budget outlines resource allocations to various PUNOs for different interventions. It covers costs related to service delivery to be executed by Triggerise through the proposed Development Impact Bond. These costs are captured under transfers and grants to counterparts and will be managed under UNFPA. UNFPA's budget also covers costs for strengthening ASRH service delivery, advocacy for public buy in and outcome fund management. UNAIDS' budget on the other hand covers costs strengthening HIV service delivery and ensuring strong linkages to treatment. UNAIDS' budget also includes funds for the SDGPP

which will be responsible for JP coordination and outreach to strategic investors and outcome payers. WHO's budget on the other hand captures costs for learning to inform advocacy, replicability and scale.

4.2 Budget per SDG targets

4.2 Budget per SDG Targets

SDG TARGETS		%	USD
	SDG 3: Ensure healthy lives and promote well-being for all at all ages	0.55	4,125,000
	SDG 5:Achieve gender equality and empower all women and girls	0.30	2,250,000
	SDG 17: Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development	0.15	1,125,000
TOTAL		**1.00**	**7,500,000**

A bulk of the funds will go towards SDG goal 3 given the primary focus of the programme. This will be followed by SDG5 given the focus on adolescent girls and lastly SGD17 in view of the programme's catalytic role in unlocking new partnerships and resources towards adolescent health.

4.3 Work plan

4.3 Work plan

Output	Annual target/s			List of activities	Time frame (Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4)	PLANNED BUDGET				PUNO/s involved	Implementing partner/s involved
Outcome 1: Reduction in adolescent birth rate with increased contraceptive prevalence rates among adolescent girls											
	Year 1	Year 2	Year 3			Overall budget description	Joint SDG Fund (USD)	PUNO Contributions (USD)	Total Cost (USD)		
Output 1.1: Increased and sustained uptake of ASRH services by adolescent girls	120,000 adolescents served with SRH services (long acting and short acting contraception)	134,000 adolescents served with SRH services (long acting and short acting contraception)	151,000 adolescents served with SRH services (long acting and short acting contraception)	ITH Platform Technology, Maintenance and Configuration		Technology related costs	282,459	-	282,459	UNFPA, UNAIDS, WHO, SDGPP	Triggerise; counties
				Coordination of ASRH service delivery (county engagements and operations)		County engagement costs (conference package, transport, communication)	122,820	-	122,820		
				Training of providers on quality ASRH service delivery and platform use		Conference package, transport costs	10,350	-	10,350		
				Training of mobilizers to support demand creation for ASRH services		Conference package, transport costs	26,939	-	26,939		
				Risk management in SRH service delivery		Ethics training, call centre, mystery clients, audits, whistle blowing help line	105,408	-	105,408		
						Sub Total	**547,976**		**547,976**		
Output 1.2: Improved attractiveness of ASRH and HIV services across public and private facilities	70% of public and private health facilities in target sites provide quality adolescent-friendly services in line with national standards	90% of public and private health facilities in target sites provide quality adolescent-friendly services in line with national standards	95% of public and private health facilities in target sites provide quality adolescent-friendly services in line with national standards	Results Based Financing (RBF) of quality measures in the public sector		RBF incentives to health facilities	517,503	-	517,503	UNFPA, UNAIDS, WHO, SDGPP	Triggerise; counties
				Rewards for services and ratings (FP and HIV tests) for rafiki and mobilizers		Rewards for mobilizers and peer referals	258,031	-	258,031		
				Baseline, midline and end line quality related surveys		consultant costs, researchers, travel costs	97,032	-	97,032		
	Less than 1% of providers receive a minimum rating score of 2 out of 5	Less than 1% of providers receive a minimum rating score of 2 out of 5	Less than 1% of providers receive a minimum rating score of 2 out of 5	Quality assurance of facilities		consultant costs for quality assurance support to health facilities	388,127	-	388,127		
				Provider branding (Signage)		Branding costs	10,868	-	10,868		
				Subscription for Voice biometrics		Biometric subscription costs	55,447	-	55,447		
						Sub Total	**1,327,008**		**1,327,008**		
						Sub total for outcome 1	**1,874,984**		**1,874,984**		

Output	Annual target/s			List of activities	Time frame (Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4)	PLANNED BUDGET				PUNO/s involved	Implementing partner/s involved
Outcome 2: Reduction in new HIV infections and AIDS related deaths among adolescent girls											
	Year 1	Year 2	Year 3			Overall budget description	Joint SDG Fund (USD)	PUNO Contributions (USD)	Total Cost (USD)		
Output 2.1 Increased HIV testing and treatment access	15,500 adolescent girls in programme sites served with HIV tests	17,300 adolescent girls in programme sites served with HIV tests	19,500 adolescent girls in programme sites served with HIV tests	ITH Platform Technology, Maintenance and Configuration		Technology related costs	282,459	-	282,459	UNFPA, UNAIDS, WHO, SDGPP	Triggerise; counties
				Coordination of HIV service delivery (county engagements and operations)		County engagement costs (conference package, transport, communication)	122,821	-	122,821		
	94% of positive adolescents followed though to treatment (ART)	95% of positive adolescents followed though to treatment (ART)	97% of positive adolescents followed though to treatment (ART)	Training of providers on quality HIV service delivery and platform use		Conference package, transport costs	10,350	-	10,350		
				Training of mobilizers to support demand creation for HIV services		Conference package, transport costs	26,939	-	26,939		
				Risk management in HIV service delivery		Ethics training, call centre, mystery clients, audits, whistle blowing help line	105,408	-	105,408		
						Sub-total for outcome 2	**547,977**		**547,977**		

Outcome 3: Increased agency of adolescent girls to exercise their sexual and reproductive health and rights											
Output	Annual target/s			List of activities	Time frame	PLANNED BUDGET				PUNO/s involved	Implementing partner/s involved
	Year 1	Year 2	Year 3		Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4	Overall budget description	Joint SDG Fund (USD)	PUNO Contributions	Total Cost (USD)		
	70% of adolescent girls demonstrating the right attitudes/intentions towards SRH and HIV service uptake	80% of adolescent girls demonstrating the right attitudes/intentions towards SRH and HIV service uptake	90% of adolescent girls demonstrating the right attitudes/intentions towards SRH and HIV service uptake	Develop and disseminate IEC materials to create knowledge and demand for SRH and HIV services among adolescents		Development, production and dissemination costs	123,879	-	123,879	UNFPA, UNAIDS, WHO, SDGPP	Triggerise; counties
				Digital campaign on SRH and HIV (social media and SMS) targetting adolescents		Internet costs, social media promotion and management costs,	15,525	0	15,525		
				Adolescent Heath promotion on SRH and HIV through Commuhity Based Organizations		costs for community based engagements with adolescents	136,141	0	136,141		
				Programme management and administration of the ITH programme		Personnel, equipment, travel, operations and indirect costs	1,973,391	0	1,973,391		
						Sub Total for outcome 3	2,248,936		2,248,936		

Outcome 4 - Increased public sector capacity to participate in user driven solutions and to provide quality ASRH and HIV services											
Output	Annual target/s			List of activities	Time frame	PLANNED BUDGET				PUNO/s involved	Implementing partner/s involved
	Year 1	Year 2	Year 3		Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4	Overall budget description	Joint SDG Fund (USD)	PUNO Contributions (USD)	Total Cost (USD)		
Output 4.1 Counties are equipped to deliver quality ASRH and HIV services in line with national and global standards	Joint programme launched			Joint programme Inception meeting and launch		Conference package, accomodation and DSA, transport costs	30,000	5,000	35,000	Lead: UNFPA &UNAIDS	Triggerise, Ministry of Health, Council of Governors, County Governments
	Quality enhancement tools on ASRH developed and disseminated in 100 facilities	Quality enhancement tools on ASRH disseminated in all 300 target facilities		Development of quality enhancement tools for Adoescent Sexual and Reproductive Health service delivery (Job-Aids, support supervision tools, quality checklist for Adolescent and Youth Friendly Services(AYFS) in the public sector		Development costs, design and printing costs and dissemination costs	30,000		30,000	Participating: WHO SDGPP	
	Patient literacy materials and job aids for HTS and treatment developed, printed and distributed to 100 health facilities	Patient literacy materials and job aids for HTS and treatment distributed to all 300 health facilities		Development and printing of adolescent friendly patient literacy materials on HIV and the revised HIV Testing Services (HTS) and treatment job aids		Cost for development, designing and printing	27,446		27,446		
	100 Health care workers trained on provision of quality adolescent friendly services	100 Health care workers trained on provision of quality adolescent friendly services		Capacity building of health care workers in target counties on provision of quality adolescent and youth friendly services based on the National Guidelines		conference costs, DSA, transport costs	30,000		30,000		
	150 Health care workers trained on differentiated service delivery and revised ART treatment guideline.	150 Health care workers trained on differentiated service delivery and revised ART treatment guideline.		Capacity building of health care workers in target counties on differentiated service delivery and revised ART treatment guidelines to promote adolescent friendly HIV service delivery.		Conference package, Transport for participants and facilitators, DSA for some participants and facilitators	90,000		90,000		
	150 Health care workers trained on the HIV testing service (HTS) guideline	150 Health care workers trained on HIV testing service (HTS) guideline		Capacity building of health care workers in target counties on HIV testing guideline		Conference package, Transport for participants and facilitators, DSA for some participants and facilitators	90,000		90,000		
	40 participants from the 10 Counties brought together to track progress, learn from each other and plan the next course of action to improve implementation.	50 participants from the 10 Counties brought together to track progress, learn from each other and plan the next course of action to improve	60 participants from the 10 Counties brought together to track progress, learn from each other and plan the next course of action to improve	Annual inter-county and County level stock taking meetings and follow up of recommendations targeting HTS, Treatment care and support cascade for adolescents		Conference package, DSA and transport	74,565	5,000	79,565		
	At least 3 strategic advocacy engagements conducted at national and county level	At least 3 strategic advocacy engagements conducted at national and county level	At least 3 strategic advocacy engagements conducted at national and county level	Strategic national and county level advocacy for commodity security, resource allocation for ASRH, and enabling an environment for access to SRH services by adolescents		Conference package, DSA and transport	60,000		60,000		
	Progress tracked in implementation of joint programme and cross learning among counties enhanced	Progress tracked in implementation of joint programme and cross learning among counties enhanced	Progress tracked in implementation of joint programme and cross learning among counties enhanced	Annual planning and review meetings bringing together all target counties to track progress in implementation, facilitate learning and make necessary adjustments		Conference package, accomodation and DSA, transport costs	90,000	5,000	95,000		
	TA provided annually to strengthen HIV service delivery in public sector	TA provided annually to strengthen HIV service delivery in public sector	TA provided annually to strengthen HIV service delivery in public sector	Technical Assistance for strengthening HIV service delivery in the public sector		Facilitation for TA at National, County and sub County - DSA and transport and TA by UNAIDS staff	80,490	100,000	180,490		
						Sub-total for Advocacy and Capacity Building	602,501	115,000	717,501		

Output 4.2 Evidence on public sector integration, Quality Improvement and innovative financing through Development Impact Bonds generated, documented and disseminated	Learning agenda developed to address knowledge gaps in design and effective implementation that is aligned policy/program needs			Consultative processes with government and incountry stakeholders to develop/refine learning agenda/quesitions on DIB design and implementation (including effectiveness)									confence costs, accomodation, DSA, transport	10,000		10,000	Lead: WHO Participating:	Triggerise, Ministry of Health, Council of Governors, County Governments
	1 study conducted based on prioritized learning questions using appropriate research methodologies	1 study conducted based on prioritized learning questions using appropriate research methodologies	1 study conducted based on prioritized learning questions using appropriate research methodologies	Conduct studies on the key learning agenda items giving attention to public sector integration in the implementation of DIBs and continous quality improvement									Consultancy costs, costs of researchers, transport costs, DSA, ethical approval costs	150,000		150,000	UNFPA UNAIDS SDGPP	
	Learning products developed to contribute to knowledge	Learning products developed to contribute to knowledge	Learning products developed to contribute to knowledge	Produce learning products (Policy briefs, Practitioners guide /Operational Notes) and publish learnings where possible									Development costs, design and printing costs	30,000		30,000		
		Policy dialogues conducted with national and county stakeholders conducted to share knowledge and inform practice	Policy dialogues conducted with national and county stakeholders conducted to share knowledge and inform practice	Hold Policy dialogues with national and county stakeholders to disseminate learnings on the joint programme									conference costs, DSA, transport costs	60,000		60,000		
		knowledge products on the joint programme shared in strategic conferences	knowledge products on the joint programme shared in strategic conferences	Utilize various learning forums (conferences, sympossiums) to share knowledge from the joint programme									conference costs, DSA, transport costs	7,500	5,000	12,500		
	Technical assistance on knowledge management provided to the Joint Programme	Technical assistance on knowledge management provided to the Joint Programme	Technical assistance on knowledge management provided to the Joint Programme	Technical assistance for the learning agenda(%)									Staff costs %	105,000	100,000	205,000		
													Sub total for Learning	**362,500**	**105,000**	**467,500**		
Output 4.3 Strengthened Coordination of the joint programme through Government-co-chaired steering committee, programme technical committee and programme implementation committee	Quarterly Steering Committee committee meetings held to provide overall oversight and strategic guidance to the joint programme	Quarterly Steering Committee committee meetings held to provide overall oversight and strategic guidance to the joint programme	Quarterly Steering Committee committee meetings held to provide overall oversight and strategic guidance to the joint programme	Convene quarterly Steering Committee committee meetings (SDG Partnership Platform Health Window) to provide overall oversight and strategic guidance to the joint programme									Conference package	15,000	5,000	20,000	Lead: SDGPP Participating: UNFPA	Triggerise, Ministry of Health, Council of Governors, County Governments
	Quarterly programme technical committee meetings held to guide programme implementation process, track progress and take corrective action where necessary	Quarterly programme technical committee meetings held to guide programme implementation process, track progress and take corrective action where necessary	Quarterly programme technical committee meetings held to guide programme implementation process, track progress and take corrective action where necessary	Hold quarterly programme technical committee meetings to guide programme implementation process, track progress and take corrective action where necessary									Refreshments	0	5,000	5,000	UNAIDS WHO	
	Quarterly programme implementation committee meetings bringing on board implementing counties held for insights on programme implementation	Quarterly programme implementation committee meetings bringing on board implementing counties held for insights on programme implementation	Quarterly programme implementation committee meetings bringing on board implementing counties held for insights on programme implementation	Hold quarterly programme implementation committee meetings bringing on board implementing counties for insights on programme implementation (3 virtual and 1 physical-midyear)									conference package	45,000		45,000		
	Joint field monitoring done across project sites to track progress	Joint field monitoring done across project sites to track progress	Joint field monitoring done across project sites to track progress	Joint field monitoring across project sites (annual) to track progress									Accomodation and DSA, transport costs	75,000	5,000	80,000		
	Technical assistance provided for joint programme coordination and strategic enagements with the public and private sector	Technical assistance provided for joint programme coordination and strategic enagements with the public and private sector	Technical assistance provided for joint programme coordination and strategic enagements with the public and private sector	Technical assistance for joint programme coordination and strategic enagements with the public and private sector(%)									Staff costs %	165,000	100,000	265000		
													Sub total for JP Coordination	**300,000**	**115,000**	**415,000**		
													Sub Total for outcome 4	**1,265,001**	**335,000**	**1,600,001**		

Outcome 5 - Diversified available pool of private and public funding for ASRH and HIV services																						
Output	Annual target/s			List of activities	Time frame												PLANNED BUDGET				PUNO/s involved	Implementing partner/s involved
	Year 1	Year 2	Year 3		Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Overall budget description	Joint SDG Fund (USD)	PUNO Contributions (USD)	Total Cost (USD)		
Outcome 5.1: Increase private and public sector funding for ASRH and HIV	The DIB officially launched and at least 1 outreach conducted at national level with potential outcome funders/investors	At least 2 outreaches conducted at national level with potential outcome funders/investors	At least 2 outreaches conducted at national level with potential outcome funders/investors	National launch of the DIB and Joint outreach to outcome fund investors at National level													Conference package, accomodation and DSA, transport costs, marketing and promotion	60,158		60,158	Lead: SDGPP/UNFPA Participating: UNFPA UNAIDS WHO	Triggerise
	Branding and communication of the joint programme	Branding and communication of the joint programme	Branding and communication of the joint programme	Conduct strategic marketing, communications, and branding of the joint programme													Development of branding materials	30,000		30,000		
	At least 3 engagements held with public institutions on prioritization and funding for ASRH and HIV services	At least 3 engagements held with public institutions on prioritization and funding for ASRH and HIV services	At least 3 engagements held with public institutions on prioritization and funding for ASRH and HIV services	Strategic engagements with national and county level public institutions on priotization and funding of ASRH and HIV programmes (counties, NHIF)													Meeting costs		5,000	5,000		
																	Sub total for diversified funding	**90,158**	**5,000**	**95,158**		
Output 5.2 Enhanced programme management and Quality Assurance provided for the joint programme	Management structures for the joint programme established and implemented	DIB management structures implemented	DIB management structures implemented	Setting up of the outcome fund management structures within UNFPA and overall management of the DIB													Fund management fees for DIB @1%, legal fees for setting management structures	70,000	10,000	80,000	Lead: UNFPA Participating: SDGPP UNAIDS WHO	
	Baseline conducted on the joint programme and targets for the DIB set	Mid-term review of the joint programme conducted to track the DIB perfomance metrics	End term review of the joint programme conducted to track the DIB perfomance metrics	External Performance Evaluation of the DIB to inform / trigger payments													Consultant fees (Performance evaluator)	250,000		250,000		
	TA provided on public sector integration of ASRH and overall programme management	TA provided on public sector integration of ASRH and overall programme management	TA provided on public sector integration of ASRH and overall programme management	Technical Assistance for public sector integration of ASRH and overall programme management (%)													Staff costs %	195,000	150,000	345,000		
																	Sub Total for Programme	**515,000**	**160,000**	**675,000**		
																	Sub Total for outcome 5	**605,158**	**165,000**	**770,158**		
																	GRAND TOTAL	**6,542,056**	**500,000**	**7,042,056**		

Annex 5. Risk Management Plan

Risks	**Risk Level:** (Likelihood x Impact)	**Likelihood** Certain - 5 Likely - 4 Possible - 3 Unlikely - 2 Rare – 1	**Impact:** Essential – 5 Major - 4 Moderate - 3 Minor - 2 Insignificant - 1	**Mitigating measures**	**Responsible Org./Person**
Contextual risks					
Covid-19 restrictions worsen, reducing girls' ability to seek services from clinics	12	4	3	ITH has seen minimal levels of performance disruption since March 2020, despite national lock downs. If conditions worsen, ITH will utilize mobile methods of service delivery including distribution of SRH products directly to girls, mobile nurses and online counselling.	Triggerise
Programmatic risks					
Triggerise is not able to meet its targets and development impact bonds are not paid out	12	3	4	As per the 1st tranche of outcome funding, real-time data from the platform was utilized to course correct rapidly when underperformance occurred. High performing interventions can be optimized, and those that are low performing can be removed. User feedback will be regularly integrated for improvement	Triggerise, CIFF, other investors.
Donated SRH commodity shortages lead to increased programme costs and/or limit programme implementation	20	5	4	While national level stock outs would potentially disrupt the cost reduction pathway, other cost reduction strategies would allow programming to continue. In extreme cases, contingency could be used to temporarily top up provider payments.	Triggerise, UNFPA

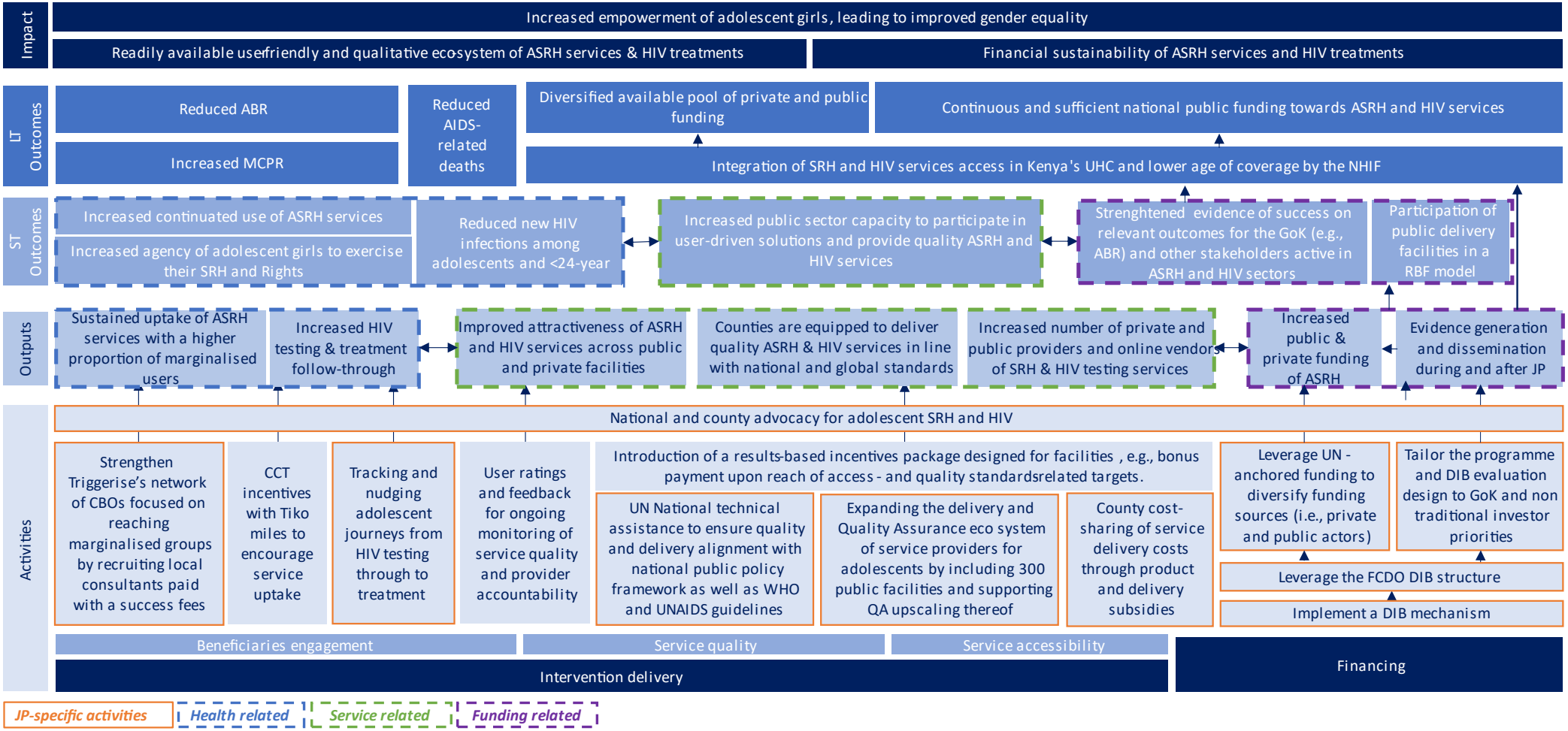
				As the JP is co-delivering the programme with counties, and building strong relationships at national level, commodity security will be improved slightly than if delivering wholly through private sector facilities Triggerise recognize there is potential commodity stock out based on donor funding cuts for contraceptives such as FCDO and USAID. To mitigate this risk, Triggerise has projected the potential impact to the programme and currently exploring different modalities to address them, namely:- 1. Explore direct procurement of commodities. 2. Explore social marketing avenues with MSK, PSI, DKT, etc. 3. Supporting counties to project county specific commodity demands and budgeting for them, etc. 4. Roll out facility level commodity stock tracking through Tiko or any other platform.	
Quality of care risks – Adverse events and complications related to poor service provision practices for SRH procedures (Implants and IUD insertion)	12	3	4	Service delivery partners working with county health management teams ensure quality service provision with good clinical outcomes through provider training, supportive supervision, quality assessments and mentorships. Quality assurance accountability mechanisms and client accountability mechanisms that take into consideration the client perspective of the quality of care provided to them are also in place.	Triggerise, UNFPA, UNAIDs, WHO
Technology risks associated with girls' empowerment and attitudes to ASRH	8	2	4	The ITH programme does not deliver a technology intervention in isolation, rather, the technology is paired with an on-the-ground tailored and localised demand generation strategy. This strategy utilises a range of grassroots and specialised community-based organisations who deploy trained mobilisers to engage with adolescents and support them in their SRH needs. Additionally, the ITH technology is simple and USSD based with very minimal risk of exposing adolescent girls to harmful content. We also acknowledge that technology can become an issue of exclusivity for those who do not have access to a phone, and so the mobilisers	

				and CBOs support girls to access services through a paper-based membership card route. For phone users, Triggerise operates a privacy by design policy wherein girls' safety is primary to the design of technology interventions and data collection. Girls go through a double consent process, wherein consent is first sought in relation to how her information is stored, and second is to ask if girls are comfortable being contacted after they have received the service. Communications on consent are available in a range of local languages. A contact centre is also available both for purposes of continuum of care wherein girls can speak with a nurse if they have questions or anxieties in relation to their SRH service. It is also a key method for Triggerise to gather feedback on user experience, and ensure girls safety in accessing services.	
Fraud and corruption losses/risks associated with cash payments i.e. subsidies for service provision and rewards for adolescents.	8	4	2	Having implemented a cash transfer based programme before, preventive, detective and responsive controls were implemented to manage fraud and corruption risks with minimal losses realized. These include the design of rewards and incentives. The rewards are in the form of a mobile currency rather than cash, and are of very low value (it rarely exceeds 0.5 USD per occasion of reward) and 'saving' options are scarce, as most behaviours we reward are monthly behaviours, limiting the option of pilling up rewards. Further for providers, verification procedures were carried out prior to payouts. Real time data analysis was used to predict potential misconduct and carry out further checks. The small amount is not conditional to 'what happens' at the clinic – participants can go for a simple consultation or opt for an SRH service. Routine attitudinal surveys will also be initiated to assess if incentives are having an implication on whether adolescents have genuine desire to take up HIV or SRH services. The financial incentives scheme will be re-examined and potentially redesigned if intentions are found to be perverse or coerced.	Triggerise

				Any confirmed losses are expected to be reported within the JP and appropriate recovery procedures initiated.	
Institutional risks					
Cultural, religious and political opposition to teenage reproductive health services causes programming challenges	8	4	2	The JP has a major buy in and advocacy component, including a GoK chaired steering committee, in order to ensure maximum government support and political buy in, and the intervention itself rests on supporting multiple existing Kenyan government policies. After 4 years of ITH implementation in Kenya, Triggerise has already secured significant support for the programme from key national and county stakeholders, and the UN collaboration will only further this trust and buy in from Government. The programme has been designed with respect for cultural and religious diversity. Triggerise works with over 40 local community-based organizations, who focus on building awareness for importance of ASRH and HIV care, and support for adolescent uptake among families, communities and local leaders.	Triggerise, UNFPA
The Kenyan government is not willing or commit significant funding towards the programme	9	3	3	10 counties have committed to co-financing the public sector delivery of the programme, and National Treasury has indicated their interest and support in the programme. The NHIF have indicated that xxx. UNFPA and the other DIB partners will centre advocacy efforts on securing government financing both the national and subnational level.	UNFPA, Triggerise
Fiduciary risks					

The JP is unable to raise sufficient outcome funding and/or investment commitments to fill ITH's funding gap	8	2	4	All JP partners have significant networks and capacity for funder engagement, and have specific remits and resources under this programme to do so. Alongside CIFF's role as anchor investor, they have already taken a significant lead in building the profile of ITH among its networks, and will provide ongoing fundraising support to the JP. As ultimate recourse, should fundraising fail despite the above, ITH will have the option to draw on a CIFF strategic grant reserve and/or reduce the programme size.	UNFPA, Triggerise, SDGPP, CIFF

Annex 5. Theory of Change



Annex 6. Communication plan goal and objectives

The JP will strategically integrate communication activities throughout the programme period to highlight its uniqueness and contribution towards the SDGs. The communication plan will be built upon a narrative showing the innovative and transformative power in adolescents and young people and the value add for the broader society of investing in ASRH. It will emphasize that when adolescents and youth are empowered to take control of their own bodies, they will also take their future in their own hands and be better positioned to fulfil their potential. By linking investments in ASRH with long-term impacts for gender equality, economic and social development, the programme will show the benefit of introducing new financing modalities to the under prioritized area of ASRH.

To contribute to the UN Joint SDG Fund overall goal of incentivizing the transformative policy shifts and stimulate the strategic investments required to get the world back on track to meet the SDGs, UNJP partners will work towards the following communications objectives:

- **Advocate** for Sexual Reproductive Health and Rights for adolescents and youth as a basic right and prerequisite for gender equality and the social and economic development of society.
- **Promote** and showcase the world's first ASRH Development Impact Bond and share successes and lessons learned to inform policy and improve design of future innovative financing instruments for catalysing investments for the attainment of the SDGs.
- **Enhance brand and profile** of UNJP partners (eg UN Joint SDG Fund and its donors, CIFF, UKAID, ITH, Triggerise, KOIS, SDG Partnership Platform, WHO, UNAIDS, UNFPA, UN Kenya) and its position as an innovative partnership for achieving the SDGs.
- **Motivate new funders** and investors to join the partnership to increase investments and sustainable financing in ASRH.
- **Empower** young girls to make life-saving health decisions and seek ASRH information and services.

The JP will achieve the above objectives by targeting its messaging to the selected audience. The key audience will be divided into three main categories namely (1) the general public incl. young girls reached through the ITH platform (2) Kenyan policy makers at county and national level and including Ministry of Health and Treasury (3) Funders and financiers (4) Partners within the health and gender sector including civil society.

Messaging will be results-oriented relying on quantitative data to emphasize achievements made. Human interest stories will highlight on-the-ground realities for the programme. All messages will be presented in the context of the development in Kenya emphasizing the role of social, cultural and economic circumstances as well as the programme's contribution to towards a broader political agenda such as the Presidential Big Four agenda on Universal Health Coverage. The programme will demonstrate tangible results and rich learnings, stimulating replicability for other regional and global audience groups.

The key messages in the communication strategy is as follows:

- The JP seeks to address the problem of teenage pregnancy and HIV infections of over 200,000 vulnerable adolescents by championing world's first ASRH Development Impact Bond in Kenya blending resources from various sources in a results based financing model towards the attainment of SDG3 and 5.
- The innovative JP will deploy the use of technology to reach adolescents, especially those who are disadvantaged, with critical lifesaving information and services.
- Every young person has the right to the highest standard of health and right to control choices on their reproductive health. The ability for young people to take control of their

sexual and reproductive health and well-being is a prerequisite for taking ownership of their future.

- The success and lessons learned from this novel partnership will incentivize a transformative policy shift and stimulate strategic investments from both public and private sector for ASRH

The communication activities will be carried out in a joint effort led by the participating UN agencies, as most of the audience is anchored locally in Kenya. Each agency will assign a communication focal person that will take active part in technical discussions to ensure communication activities are aligned with programme strategies. This team will review reach of communication outreach efforts by keeping oversight of social media and website engagements including tracking increases in followers and interaction with social media posts. For communication activities that aim to incentivize new funders, all partners in the JP will contribute to taking advantages of their networks and available outreach platforms. Main communication platforms and tools include social media, website, written media as well as stakeholder meetings

All material for publication will go through a quality assurance cycle, which will aid in the creation of content that is engaging, accessible, clear, concise, and inclusive. The table below outlines a three year budgeted communication plan with proposed indicators to measure impact.

Communication objective	Activity	Indicator	3Y Target	Means of verification	Timeline and Budget				Funding (USD)	Own contribution (USD)	Lead PUNO
					Y 1	Y 2	Y 3	Total (USD)			
ASRH-R advocacy Integrated within outcome 3 activities of the WP	Advocacy through the UNJP Steering Committee and programme committee	#high-level advocacy engagements	24	Minutes of committee meetings	X	X	X	37.000	21.000	16.000	UNAIDS
	Further advocacy through engagements at national and county level	#targeted advocacy engagements	12	Workshop and joint-mission reports	X	X	X	35.000	25.000	10.000	UNAIDS
Sharing of successes & lessons learned Integrated within outcome 3 activities of the WP	Facilitate policy dialogues on implementation of DIBs to generate and capture experiential knowledge	#policy dialogues organized	12	Policy dialogue reports	X	X	X	35.000	30.000	5.000	WHO
	Dissemination of learning products (policy briefs, practitioners guide /operational Notes)	#learning materials disseminated	12	Learning materials & distribution lists	X	X	X	5.000	2.500	2.500	WHO
Enhance brand and profile of UNJP partners Integrated within outcome 4 activities of the WP	Organize launch & facilitate additional high-level engagements for UNJP partners in high-profile events (eg UNGA, WHA, WEF, Sankalp)	#high-level engagements facilitated	12	Event reports	X	X	X	20.000	15.000	5.000	UNFPA
	Develop and disseminate digital newsletter	#newsletter disseminated	12	Newsletters and	X	X	X	9.000	9.000		UNFPA

	in which all UNJP partners are promoted			distribution list							
	Develop social media toolkit in which UNJP partners are acknowledged	#social media engagements	36	Social media analytics	X	X	X	10.000	5.000	5.000	UNFPA
Motivate new funders and investors to join the partnership Integrated within outcome 4 activities of the WP	Develop and disseminate marketing materials for information and visibility purposes	#marketing materials	9	Marketing materials	X	X	X	1.500	1.500	1.500	UNFPA
	Field missions for collection of programme case studies and audio visual communication s assets including photographs and videos	#field missions organized	6	Communications materials and case studies	X	X	X	6.000	6.000	6.000	UNFPA
	Engage in webinars to market the partnership and DIB	#webinars	12	Webinar invitations / summary	X	X	X	5.000		5.000	UNFPA
	Conference attendance for panels, presentations etc (e.g ICFP, Women Deliver)	#conferences	3	Conference presentations		X	X	5.000		5.000	UNFPA
	Strategic outreach to potential new funders/investors (biteral and through roundtables)	#funders/ investors reached out to	18	Quarterly outreach summary	X	X	X	7.000	3.000	4.000	UNFPA

Annex 7. Learning and Sharing Plan

1) Strategic approach to learning and sharing

The focus of the learning agenda is to fill the existing gaps with regards to knowledge on the design and implementation of blended financing instruments including development impact bonds(DIBs) in of Kenya among the UNCT, government and other partners. The implementation of the learning agenda will be to generate evidence to guide adaptation of the ASRH DIB and inform policy towards ownership/institutionalization of DIB implementation within health sector in Kenya and the African region. This is meant to contribute to the agenda of preparing Kenya from transitioning from concessional donor funding.

We will leverage the UN thought leadership (through WHO as the lead for the learning agenda) to lead learning on this nascent area of DIBs. One of the core functions of WHO is to, *"Shape the research agenda and stimulate the generation, translation and dissemination of valuable knowledge"*. Through the SDG Partnership Platform, we will continue to strengthen the existing collaborations with national institutions around public private partnerships in health such as Strathmore Business School, Duke Global Health Innovation Centre and Innovations in Healthcare and other universities working in related areas. To leverage regional and global learning initiatives, we will link the learning activities to the African Health Observatory Platform (AHOP) on Health Systems and Policies which is hosted by the WHO Regional Office

for Africa. Within Kenya, the AHOP partner for knowledge generation and translation is the KEMRI Welcome Trust.

2) Objectives of learning and sharing

While the learning plan will be further refined with the key partners and stakeholders as part of the process of building buy-in and ensuring production of policy relevant evidence/knowledge, the following are the proposed areas of investigation:

a) Explore factors that facilitate successful design and implementation of the ASRH DIB in both the private and public sector facilities in Kenya. This objective will use realist evaluation approaches to understand; what works in the context of design and implementation of DIBs and the context in which these may be triggered so as to achieve the desired programmatic and financial outputs/outcomes.
b) Assess the development(effectiveness) and financial additionality as a result of implementation of the ASRH DIB in Kenya. To measure outcome/output additionality, we will use appropriate quasi-experimental approaches to estimate the improvement in outcomes that can be directly attributed to using the DIB approach as compared to status quo/alternative approaches for using public/concessional funds. For financial additionality, the focus will be on estimating the additional private resources crowded in due to the DIB. This assessment will take into consideration the potential differentials arising from use of private versus public sector providers enrolled on the ITH platform.
c) Assess the cost effectiveness/efficiency of implementation of DIB compared to status quo/alternative approaches. Building on the above objective, efficiency of the intervention will be based on comparison of the cost per additional gains in outcomes as implementing the DIB compared to the status quo.
d) Explore the sustainability pathways and mechanisms of reducing the time and transaction costs required to raise outcomes funding in the context of the health system also drawing lessons for Sub-Saharan Africa.

The main sources of data from all the proposed learning objectives below are: key informant interviews from national and county level and health output/outcome data from the health facilities and the ITH platform. The learning agenda will also benefit from household survey data collected by the evaluators as part of the evaluation to inform DIB reimbursement process. Additional data sources will be identified at inception phase based on the agreed refined learning questions and learning agenda.

3) Main activities

To in order to achieve the objectives outline above, we will implement the activities described below. The implementation will be led by WHO with support of the other joint program partners.

a. Consultative processes with stakeholders for buy in of the learning agenda, refine it and collaborate on implementation. This will be implemented in the form of a workshop with the key outputs expected to be a workshop report with refined/prioritized questions that has been agreed upon by all stakeholders with the plan for its implementation and dissemination. This workshop will be implemented in the first year of implementation. This will be implemented in Year 1.

b. Implement or research studies and analyses based on implementation prioritized learning questions. This will be implemented across the 3 years of the DIB implementation. The main outputs of these are the learning products that will feed into the policy dialogues

and further dissemination including in investor and academic forums. The key learning products to be generated are:

- Research reports,
- Policy briefs
- Practitioners guide /Operational Notes
- Online and multimedia resources such as websites such as the SDGPP website, AHOP platform
- In-person events, including presentations, study tours at implementation sites during implementation

k. Policy dialogues on implementation of DIBs to generate and capture experiential knowledge as part of the implementation and inform any necessary adaption during implementation. These dialogues will act as a nucleus for forming an in-country learning network drawing from public sector and private sector players in health including: Ministries of Health, National Treasury at both national and county level, development partners, investors and academia

Annex 8. Comparative instrument analysis

A DIB was selected based on a comparative instrument analysis in several steps.

First, a menu of possible financing mechanisms was considered – including both innovative financial mechanisms and traditional grant funding. Each mechanism was assessed against pre-identified relevance, feasibility and actionability criteria. The criteria were jointly developed by the JP partners and tailored to the funding requirements of the JP:

- Relevance criteria:
  - Does it seize the potential of financial innovation by (i) attracting new financing from the private sector and (ii) diversifying the sources of funding?
  - Does it have the potential to leverage in-country public financing (foster government as a leader)?
  - How catalytic is the SDGF financing contribution?
  - Does it foster a long-term sustainable financing solution?
  - What is the replication potential of the financial mechanism?
- Feasibility criteria:
  - Does the risk bearing entity have capacity and willingness to assume the risk?
  - How feasible is it to raise the necessary funding and from which type of parties?
  - Is there track record and other data available to set the disbursement payment criteria?
- Actionability:
  - What are the transaction costs?
  - What is the timeline to set up this instrument?

Based on this assessment, grant funding was ruled out as an option for the programme due to i) low financial innovation, ii) little incentive to diversify sources of funding and potential to leverage public funding, and iii) low ability to foster long-term sustainable financing for the programme. Instead, the assessment informed us that a subset of results-based finance (RBF) mechanisms could be considered relevant for the programme considering their ability to incentivize results, increase accountability and optimize the use of potential public resources. Notably, three RBF mechanisms were identified as having high-potential to attract sufficient capital to fund ITH's intervention within the JP:

- *Development impact bond:* Social investors provide upfront financing to the implementer to carry out the intervention. Following/throughout the intervention, an independent

evaluator rigorously measures the intervention's outcomes. If the pre-defined outcomes are achieved, an outcome funder repays the invested capital, plus a risk premium, to the investors.

- *Performance-based non-reimbursable loan:* The implementer does not have sufficient capital to carry out the intervention and therefore has to resort to external financing. It takes an interest-free (or a low-interest) loan from a donor to cover the necessary capital to implement the intervention. Upon delivering the pre-defined results, the loan notional amount is fully/partially waived (i.e., the donor ends up paying only in case of a successful intervention).
- *Pay-for-success on delivery:* The implementer has sufficient financial capacity to bear the operating risk of carrying out the intervention (whether it is through self-financing or raising upfront grants/debt capital elsewhere) and is reimbursed ex-post upon delivering the pre-defined results.

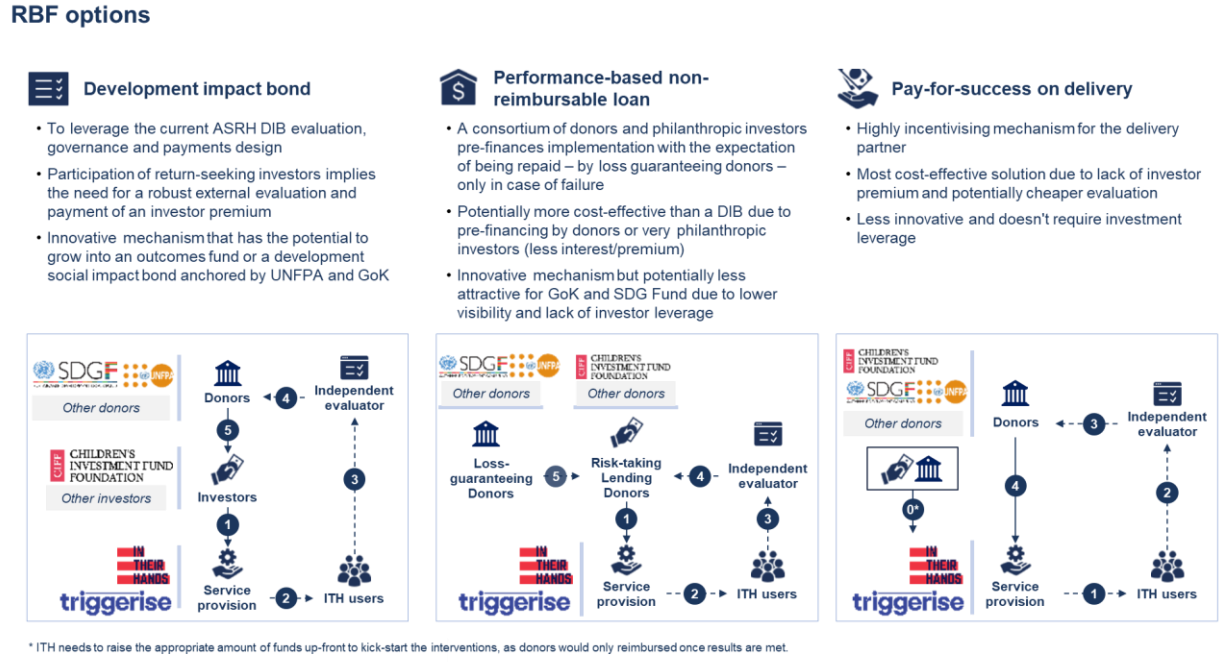
Key characteristics of the shortlisted RBF mechanisms

	Development impact bond	**Performance-based non-reimbursable loan**	**Pay-for-success of delivery**
Focus on outcomes	- Impact bonds focus by design on measuring outcomes in a more robust way than grants and other performance-based contracts - The evaluation method strives to ensure a rigorous attribution of the outcomes to the intervention	- The focus on outcomes depends on the ambition of the contract and can vary significantly - Depending on the way the performance contract is structured, only part of the funding might be tied to outcomes	- The focus on outcomes depends on the ambition of the contract and can vary significantly - Depending on the way the performance contract is structured, only part of the funding might be tied to outcomes
Risk transfer	- Impact bonds allow donors to tie payments to achievement of outcomes, while externalizing the risk to investors (and in some cases also partially to the service provider).	- Risk is transferred to the implementer to the extent of their own working capital invested to cover the full upfront capital required - Credit risk remains with the lender (i.e., donor) until a full repayment of the loan provided to the implementer (who, in case of poor performance, might not be able to fully repay the amount due).	- Risk is transferred to the implementer to the extent of their own working capital invested to cover the full upfront capital required (up to 100%).
Cost effectiveness	- Impact bonds need to justify the returns paid to investors by ensuring the intervention is generating additional savings (vs. status quo) - The reputational risk of not meeting outcome targets can provide an extra push for service providers to improve cost effectiveness	- While performance-based contracts do not require the intervention to be cost-effective, donors generally embed cost effectiveness into the performance targets - Implementers are inherently incentivized to achieve cost effectiveness as they directly benefit from cost savings	- While performance-based contracts do not require the intervention to be cost-effective, donors generally embed cost effectiveness into the performance targets - Implementers are inherently incentivized to achieve cost effectiveness as they directly benefit from cost savings

Performance management	- Impact bonds require a strong performance management approach given that the payment to social investors depends on achieving the pre-defined outcomes	- Performance-based contracts focus on performance management as part of the payment is tied to achieving the outcome	- Performance-based contracts focus on performance management as part of the payment is tied to achieving the outcome
Transaction costs	- Impact bonds have high transaction costs as they require fees for the structuring, legal and evaluation workstreams - Impact bonds require a significant time allocation from all the stakeholders involved	- Performance-based contracts include transaction costs given that performance needs to be measured following the implementation of the intervention	- Performance-based contracts include transaction costs given that performance needs to be measured following the implementation of the intervention

The second step involved a detailed analysis of the various parameters of each of these three mechanisms. Notably, the contractual structures of the mechanisms were envisaged, specifying the envisioned role of each programme partner. The aim of this exercise was to assess in detail the added value of each instrument towards attracting sustainable financing of the programme as well as to test partner ability and appetite to take on various roles in the short – and long-term.

Extract of the intermediary high-level assessment



Analysis grid of considered financial mechanisms

	Development impact bond	Performance-based non-reimbursable loan	Pay-for-success on delivery
Who is the risk bearer?	Triggerise will seek an interest free or low-interest loan from (a) philanthropic investor(s) or donor(s). Depending on the terms of the loan, Triggerise will have to reimburse all or part of the loan at the end of implementation if the result targets are not met.	Implementation risk is borne by the investors; The level of risk, and thus of investor remuneration, will depend on how ambitious the result targets are. Risk can be mitigated with a capital guarantee provided by the outcome funders or (an) other donor(s). In the First ASRH DIB apparent investor risk/reward was low, but this might be because the targets were low.	Triggerise will have to fund the implementation from its own resources or find an unconditional grant. Implementation costs will be paid back to Triggerise – possibly with a success bonus – by (a) donor(s) who has committed to paying for the results.
What risk will it be prepared to bear?	This instrument supposes that Triggerise finds a source of funding to reimburse the loan in case of total or partial failure to deliver the results.	The implementation budget is a considerable amount to raise from investors – possibly unrealistic. Solution: breakdown into 2 or 3 implementation periods and recycle the cashflows.	what amount would be feasible to raise?
Upfront capital commitments to be raised Who from?	Donor(s) willing to make a performance-based loan	Social investors	Triggerise own resources or from an unconditional grantor
Upfront capital commitments to be raised **By whom?**	Triggerise supported by the JP	Triggerise & JP, possibly supported by an intermediary	Triggerise supported by JP
What types of outcomes need to be measured under the instrument?	A mix of short – and long-term outcomes could be envisaged in case the loan is made in a layered structure (i.e., shorter-term tranches of the loan waived based on short-term outcomes) to provide Triggerise with more visibility on their fundraising need, as well as a better course correction throughout the programme implementation. It is also possible to have several lenders, each providing a different tranche of the loan	While long-term outcomes could be the sole payment metric(s), it is preferable to have a mix of both short – and long-term outcomes to provide Triggerise the possibility to course correct throughout programme implementation. This would also allow to opt for a DIB with recycling of cashflows, thereby reducing the ask from investors and lowering the investor premium amount. A DIB would allow to build on the evaluation from the FDCO DIB, while adding long-term outcomes (such as ABR), which were not feasible in the First ASRH DIB due to the insufficient time (e.g., outcome funders could pay for the realization of long-term impact if we manage to build up on the outcomes measured in the first tranche).	Some short-term outputs/outcomes will have to be measured to allow for more frequent payment milestones (e.g., every 3 or 6 months) to ease up the pressure on Triggerise to fundraise. These could include indicators such as the number of public facilities joining the programme, number of first-time users, etc. Additionally, long-term outcomes (e.g., adolescent birth rate, number of public facilities offering appropriate quality services, etc.) can be measured upon the donor(s)' request.

Who does the evaluation?	Data collection from the services delivery partner and verification by an independent external party especially for outcomes.	As in the First ASRH DIB, investors will likely require an external evaluation.	Data collection from the services delivery partner and verification by an independent external party especially for outcomes (if long enough timeframe to do so).
Who does the performance management?	Programme performance is 100% driven by Triggerise – except for the items which strongly benefitted from PUNO support.	Depending on the governance structure of the DIB, investors will have a performance management role – or not- through a third-party 'performance manager' – or not.	Programme performance is 100% driven by Triggerise –except for the items which strongly benefitted from PUNO support.
Performance attribution and implications for Exit	Given that PUNO support is largely to support the integration of the public units and reinforcement in HIV response, it is safe to gauge that public buyers will trust the programme's results to be replicable, even after withdrawal of PUNO support.	Investor performance management can lead to questions as to performance attribution and replicability (without support from an outside performance manager).	Given that PUNO support is largely to support the integration of the public units and reinforcement in HIV response, it is safe to gauge that public buyers will trust the programme's results to be replicable, even after withdrawal of PUNO support.
Estimated timeline to launch	- Both mechanisms require significant fundraising and innovative contractual structures for most of the funding parties - The DIB requires to raise larger amounts, unless CIFF and/or FCDO wish to prolong the first DIB through successive tranches, which would significantly reduce the need for fundraising. - Despite the complexity of setting up a DIB, the fact that there is an existing framework that can be leveraged and potential repeat investment and outcome funding by FCDO (to be confirmed) weigh in favour of this instrument.		Triggerise pre-finances activities and SDGF pays for success along with other donors and GoK → more risk on Triggerise → shorter fundraising, more actionable.
Estimated transaction costs	**MEDIUM/HIGH**	**MEDIUM**	**LOW**
How attractive is this solution for the public facilities and GoK	More rigorous evaluation framework can be leveraged for future outcomes commissioning/public purchasing framework Attractiveness for GoK of public facilities being indirectly part of an innovative financing structure (albeit maybe less visible than a DIB).	More rigorous evaluation framework can be leveraged for future outcomes commissioning/public purchasing framework. Attractiveness for GoK of public facilities being indirectly part of a Development Impact Bond (through implementation)	Incentivization of public delivery units and alignment with Triggerise's incentives should be attractive, but the financial mechanism less so. Likely less sophisticated evaluation framework
How attractive is this solution for the SDG Fund?	Innovative solution involving the SDG Fund in a guarantor/first-loss role Pre-financing is made by philanthropic investors or donors who might be private	Is innovative and involves the need for private investment; in theory has better potential to lead to government outcomes commissioning (in practice there are few such successful examples).	Lower tech, less innovative, solution Doesn't involve investors

Based on this detailed comparative analysis, the development impact bond demonstrated most potential for the programme. There are four main reasons for this:

- *Financial innovation:* the DIB has strong potential to attract new investors (both private and public) looking for social returns in addition to financial returns. It also has the potential to attract new diversified funding sources by de-risking donors who will pay for realized outcomes only and setting the targets in line with their development priorities. Indeed, by transferring the risk to investors, the risk of non-performance is reduced (or even fully avoided) for donors. In contrast, while the performance-based non-reimbursable loan and the pay-for-success on delivery mechanisms have the potential to attract new outcome-focused donors, they have less ability to attract a diverse set of investors. Notably, the grant structure of the pay-for-success on delivery mechanism keeps the scope of potential stakeholders limited to philanthropic and public institutional actors (i.e., limited scope for private investment).
- *Leverage of the First ASRH DIB:* while impact bonds mechanisms typically have high transaction costs, the DIB mechanism is uniquely positioned for leveraging of the First ASRH DIB's evaluation, governance and payment design. Doing so does not only reduce transaction costs, making it more attractive for all parties, but enables the DIB to leverage learnings and avoid any missteps in the current Second ASRH DIB.
- *Sustainable financing:* the DIB has a strong potential to grow into an outcomes fund or a development social impact bond anchored by UNFPA and GoK – contributing to the long-term sustainability of the programme. While the degree of sustainability of the programme will largely depend on the willingness of the GoK to take on a greater role, the DIB is likely to be more attractive to the GoK than the other mechanisms due to higher visibility and investor leverage.

Feasibility of the envisioned roles: the roles to be taken on by the various parties were proven most feasible in the DIB structure. Notably, the feasibility and willingness of the risk bearing entity to take on risks are significantly higher in a DIB than in the other two mechanisms. Indeed, in the DIB risks are transferred to social investors that are well placed to play this role and are remunerated therefore. In contrast, in the other mechanisms, Triggerise, as the risk bearer, would have to fund the implementation from its own resources (pay-for-success on delivery), which is unfeasible due to the size of the programme, or seek a loan from an investor (performance-based-non-reimbursable loan).

Annex 9. Stakeholder roles

Actor	Role	Role during 'transition to sustainability' phase 2022–2025	Role 2025+
ASRH programme delivery			
Triggerise	Implementing partner	- Design of the operating plan and KPIs, in alignment with the JP's objectives - Manage day-to-day programme operations/delivery: support of its ecosystem actors – public and private clinics and pharmacies – , as well as demand generation partners and mobilizers. - Source and contract ASRH delivery partners - Manage the technology platform including additional configuration needs - Collect and analyse data towards lessons learnt and programme reporting - Manage the quality assurance of ecosystem clinics and pharmacies - Manage client feedback through platform SMS-based feedback and routine client surveys and verification via its contact centre - Safeguard and manage risks across the intervention - Ensure accountability to investors	- Full transfer of knowledge to public providers of ASRH services delivery - Provide quality assurance to public and private providers - Provide technology and associated configurations to support ongoing use of the platform - Technical assistance to public sector for using platform data for optimized service delivery and consumer engagement
County governments	Service delivery partner	- Deliver contraceptives, HIV testing and treatment services - Provide day-to-day quality assurance - Demand generation among adolescents for SRH and HIV services - Provide service data on ITH platform	- Scale-up the delivery of quality adolescent SRH and HIV services in all Kenyan counties - Fund automatically and sufficiently ASRH and HIV care
Private sector health provider and pharmacy networks	Service delivery partners	- Deliver contraceptive and HIV testing services - Provide day-to-day quality assurance - Verify service data on ITH platform	- Continue quality ASRH and HIV testing service provision, funded by NHIF reimbursements - Ongoing utilization of ITH digital platform, with co-financing from NHIF reimbursements
Community Based Organizations	Demand generation partners	- Community-based outreach to adolescents to build awareness for ITH services; focus on marginalized adolescent groups - Enrol adolescents on the ITH platform - Build community, partner and parent buy-in for adolescent SRH and HIV access	- Transition to government community mobilizers for awareness and buy-in building among adolescents and communities - Continue specialized CBOs outreach to hard-to-reach groups
Technical assistance			
UN JP partners (UNFPA,	Delivery technical assistance partners	- Develop and deliver key quality improvement initiatives, tools and trainings to county facilities - Build capacities of health workers in line with national guidelines	- Lead dissemination of key programme learnings

Actor	Role	Role during 'transition to sustainability' phase 2022–2025	Role 2025+
UNAIDS, WHO)		- Advocacy at the county and national level for commodity security and resource allocation for ASRH - Lead government co-chaired steering committees, and programme committees - Develop learning agenda and leads key research initiatives - Produce learning products, and manages dissemination plan for key evidence and research - Hold policy dialogues with government stakeholders to disseminate programme learnings - Outreach and marketing to potential funders and investors for ongoing fundraising for ITH and the JP	- Support replication of programme into other markets - Ongoing advocacy surrounding national funding allocation for ASRH and HIV care
SDG Partnership Platform Secretariat at UN RCO	Strategic coordination partner	- Coordinate JP partners - Catalyse new investments and outcome funding utilizing SDGPP networks - Support overall marketing, media and communications of the JP and the DIB	Support profile raising for dissemination of key programme learnings
Funding			
UNFPA	Outcomes Fund Manager	- Define fund strategy, operating guidelines and outcome objectives - Ensure alignment of outcome objectives with public health policy priorities - Support in raising outcomes and grant funding from multi-, bilateral, and private partners - Lead the DIB structuring and launch work - Validate the final evaluation report - Coordinate the Fund's disbursements against achieved outcomes - Support the dissemination of learnings	Lead replication to other markets
SDG Joint Fund (through UNFPA)	Outcome funders	- Provide the initial $ 5m catalytic grant to UNFPA that enables the latter's outcome funding commitment to the DIB and triggers the set-up of its outcomes fund. - Provide the $ 2m grant that enables UN catalytic TA to Triggerise.	To be defined
Anticipated new public and private donors		- Support definition of fund strategy and operating guidelines and outcomes objectives - Pluri-annual funding commitment to the outcomes fund - Support the Fund in raising funding from bilateral and private donor partners. - Contribute to DIB structuring - Review overall project progress	Participate to follow on DIBs

Actor	Role	Role during 'transition to sustainability' phase 2022–2025	Role 2025+
CIFF	Social investors	- Provide first investor letter of interest, providing comfort to potential new investors - Prefinance up to 1/3 of ITH implementation at risk - Support investor and outcome funder fund raising - Contribute to DIB structuring - Lead or delegate performance management role	No longer a core backer, but focus on priority projects including innovation pilots and government advocacy
Anticipated new investors		- Prefinance 2/3 of ITH implementation at risk - Contribute to DIB structuring - Lead or delegate performance management role	
County Governments	Programme co-financiers	- Co-finance ITH intervention via the public facilities	Provide sufficient funding to ASRH and HIV care
To be selected	Third-party evaluator	- Audit ITH data and perform data collection and evaluation of non-programme data related metrics - Deliver final evaluation report and payments recommendation to UNFPA and other outcome funders	
KOIS	First ASRH DIB structurer	- Design the outcome metrics of the first DIB and targets, built the financial model, and supported stakeholder negotiations and contracting - Support UNFPA and the JP partners in delivering this proposal, with a focus on instrument design and stakeholder engagement	
To be selected	Intermediary (impact bond specialist)	- One-year support of UNFPA and the JP to finalize the design, fund raise and launch of the Second ASRH DIB	

Annex 10. Envisaged DIB terms, payment metrics analysis and cashflow schedule shared with potential investors and donors

Contractual structure

A similar contracting structure is envisaged as for the First ASRH DIB *(see the first ARSH DIB structure in Annex 15)*, with investors, jointly or individually, entering into:

- A direct outcomes contract with a UNFPA-managed pool of grants and outcome funding;
- A grant for services contract with Triggerise, combined with investor performance management.

Terms

Investment amount:	$ 16m
Upfront commitment requirement:	$ 8m-9m unconditional, renewable after 18 months
Outcome funding budget:	$ 18m + evaluation costs + potential provider success bonus
Duration:	42 months (2x18 months/programme implementation + 6 months/final evaluation results)
Indicative max IRR:	13.5% (ROI : 10.7%, ARR: 3%)
Capital guarantee:	tbd

Payment metrics example

Metrics, e.g.								
TOTAL	**Unit value**	**Total USD value**	**Max cum. IRR**	**Max. ROI**	**Max. ARR**	*Capital repayment*	*IRR*	*ROI*
Primary metric (Visits)	$ 24.849	$ 13,684,749	-24.07%	-16.31%	-4.96%	*90%*	*NA*	*NA*
Second metric (HIV-testing)		$ 2,667,240	0.00%	16.31%	4.41%	*10%*	*NA*	*NA*
HIV follow-through metric								
Third metric (MCPR)		$ 750,000	6.49%	4.59%	1.29%	*NA*	*48%*	*43%*
Fourth metric (ABR)		$ 1,000,000	13.65%	6.12%	1.71%	*NA*	*52%*	*57%*
		$ 18,101,988	13.65%	10.70%	2.95%	100.0%	100.0%	100.0%

Payment metrics analysis to anticipate final structuring

	Outcomes	Indicators	Baseline & track record data availability	Recom. timeline to measurement	Feasibility (assuming acceptance of average attribution rigour)	Implications for instrument
SRH	**Increased and sustained use of Sexual and Reproductive Health services**	- Percentage of girls of reproductive age who have their need for family planning satisfied with modern	- Kenya DHS 2022 (i.e., Percentage of demand satisfied by modern methods) - First ASRH DIB end line data	12 months	HIGH. Can be done through: - Matching – Individual survey in ITH and non-ITH counties - Pre-post – Individual survey in ITH counties at baseline and end line.	- CPR feasible for all three instruments, including for a DIB with recycling. - Continuation of uptake can be measured at the end of the 3-years for the first 'cohort' (can also

		methods (SDG 3.7.1) - Contraception Prevalence Rate				be added as a bonus payment in the second period of a DIB with recycling).
		Proportion of girls who make their own informed decisions regarding sexual relations, contraceptive use and reproductive healthcare (SDG 5.6)	Kenya DHS 2022 (i.e., informed choice)	12 months	HIGH. Through matching or pre-post surveys, but difficult to tie payments to.	Feasible as nonpayment metric – independent of the instrument.
	Reduced adolescent pregnancy rate	Adolescent birth rate (ABR) (10–14, 15–19) per 1,000 women (SDG 3.7.2)	Kenya DHS 2022 (i.e., Adolescent birth rate[1])	5 years	LOW. Has a higher likelihood of being influenced by external factors than CPR. Would thus require RCT to be validly measured.	Feasibility requires: - Long-term pre-financing commitment (possible measurement & repayment several months/years after the end of the programme) - High evaluation budget
HIV	**Reduced new HIV infections among adolescents and>24-year youth**	HIV testing pet 1,000 15–19 population	Kenya DHS 2022	12 months	HIGH matching with non – ITH counties or historical baseline (caveat: attribution could be harder to certify as external factors can impact the performance)	Feasible for all three instruments, as payment metric
	Improved HIV treatment adherence rates	Positive tests to treatment follow-through	- Kenya DHS 2022 (i.e., Women and men seeking treatment for STIs[3]) - Triggerise platform data	18 months	- Pre-post – individual surveys	Sensitivity implies low suitability for payment metrics
	Reduction in AIDS-related deaths	Viral load suppression	N/A	Min. 12 months[4] per cohort	- Pre-post – individual surveys	Sensitivity implies low suitability for payment metrics

Quality & efficiency	**Increased quality scores across private and public clinic ecosystem**	Information to uptake conversion rates	- First ASRH DIB endline data (Feb. 2022) - Triggerise platform data	2 years	HIGH. Through platform and ward data/pre-post/with external validation	Feasible as payment metric for all three instruments, but DIB would likely require higher degree of external verification of results.
	Strengthened ability of public units to participate in user-driven solutions	Continuation of services	Facilities data collection	[Training of the public facilities] + 12 months monitoring (TBC)	HIGH. Through platform and ward data/pre-post/with external validation	Continuation of uptake can be measured at the end of the 3-years for the first 'cohort' (can also be added as a bonus payment in the second period of a DIB with recycling).
		Data usage	Triggerise platform	Ongoing monitoring (accessible with Triggerise data?)		
		Cost per user	ITH track record + First ASRH DIB data	Ongoing monitoring (accessible with Triggerise data?)	HIGH. EL vs BL Recommend monitoring effect of business model transition	Feasible as payment metric for all three instruments. To recommend setting objectives under constraints (e.g. services and ward-type mix and quality benchmarks)

<u>Cashflow schedule</u>

The First ASRH DIB has confirmed the quality of Triggerise's data collection tools, meaning that external third-party auditing of programme data can be completed within one month of any quarter end. This creates an opportunity to make investor repayments towards visits (the proposed first payment metric, cf. below), or another short-term metric, every four months to investors – starting seven months after programme launch; payments towards an HIV services metric (or an mCPR metric), on the same dates, thereby enabling a low double digit IRR proposition without fundamentally changing donor value-for-money compared to the current DIB. Bringing investor capital repayment cashflows forward in this way will facilitate:

- The potential generation of a low double-digit IRR without compromising the quality of the evaluation, nor fundamentally changing donor value-for-money compared to the First ASRH DIB;
- Participation of donors who can pay for delivered services but cannot contribute to private investor profits to the outcomes funding pool.

In the table below it is envisaged that:

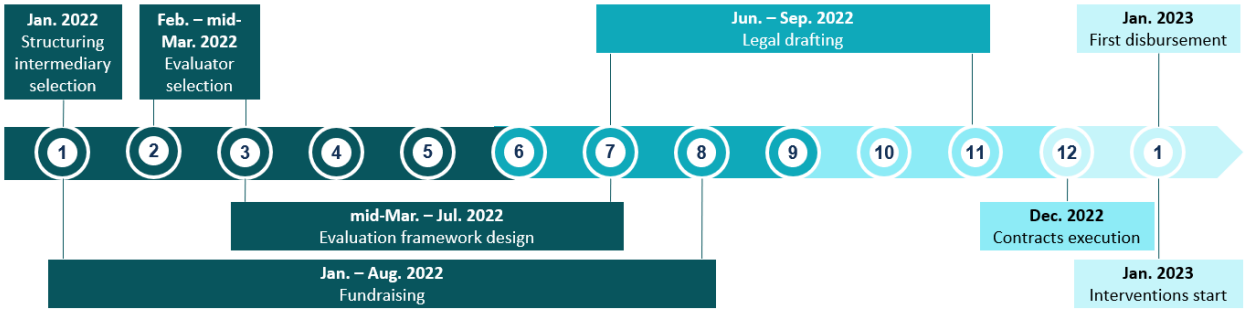
- 90% and 10% of capital repayment respectively are generated from SRH visits and HIV services (or a short-term mCPR metric) while ~ 45% of investor profits would stem from an mCPR or HIV-related outcome and ~ 55% of ROI would be tied to ABR;
- If minimum pre-agreed result targets have been reached at programme midlife (18 months), investors will recycle their initial commitment to finance an additional 18 months of implementation; this 'recycling' mechanism has the additional advantage of potentially allowing the launch of the DIB and underlying intervention before having secured the full outcome funding amount required for the repayment of three years of programme costs plus the longer-term outcome payments.

Investor cashflows assuming maximum targets are reached on both metrics

	Year 1					Year 2						Year 3						Final outcome payments			TOTAL
																		Services	MCPR	ABR	
	01/01/2023	01/07/2023	31/07/2023	31/10/2023	01/01/2024	31/01/2024	30/04/2024	01/07/2024	31/07/2024	31/10/2024	01/01/2025	31/01/2025	30/04/2025	01/07/2025	31/07/2025	31/10/2025	31/01/2026	31/03/2026	30/06/2026	
Investor drawdowns																					
Program related Budget - %	20.0%	15.0%			20.0%			15.0%			20.0%			10%							100%
Program-related drawdowns	$3,270,398	$2,452,798			$3,270,398			$2,452,798			$3,270,398			$1,635,199							$ 16,351,988
Investor financed DIB expenses																					$ -
Financing drawdown	$ 3,270,398	$ 2,452,798	$ -	$ -	$ 3,270,398	$ -	$ -	$ 2,452,798	$ -	$ -	$ 3,270,398	$ -	$ -	$ 1,635,199	$ -	$ -	$ -	$ -	$ -		$ 16,351,988
cumulated investor drawdowns	*$ 3,270,398*	*$ 5,723,196*	*$ 5,723,196*	*$ 5,723,196*	*$ 8,993,594*	*$ 8,993,594*	*$ 8,993,594*	*$ 11,446,392*	*$ 11,446,392*	*$ 11,446,392*	*$ 14,716,790*	*$ 14,716,790*	*$ 14,716,790*	*$ 16,351,988*	*$ 16,351,988*	*$ 16,351,988*	*$ 16,351,988*	*$ 16,351,988*	*$ 16,351,988*		
commitment drawdown %	*20.00%*	*15.00%*	*0.00%*	*0.00%*	*20.00%*	*0.00%*	*0.00%*	*15.00%*	*0.00%*	*0.00%*	*20.00%*	*0.00%*	*0.00%*	*10.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*	*0.00%*		*100.0%*
		35.00%	*35.00%*	*35.00%*	*55.00%*	*55.00%*	*55.00%*	*70.00%*	*70.00%*	*70.00%*	*90.00%*	*90.00%*	*90.00%*	*100.00%*	*100.00%*	*100.00%*	*100.00%*	*100.00%*	*100.00%*		
Payments tied to primary metric																					
Payment for results - Primary metric			$ 2,036,939	$ 1,018,469		$ 1,018,469	$ 1,144,151		$ 1,144,151	$ 1,144,151	$ -	$ 1,144,151	$ 1,258,566		$ 1,258,566	$ 1,258,566	$ 1,258,566				$ 13,684,749
Total inflow primary metric	$ -	$ -	$ 2,036,939	$ 1,018,469	$ -	$ 1,018,469	$ 1,144,151	$ -	$ 1,144,151	$ 1,144,151	$ -	$ 1,144,151	$ 1,258,566		$ 1,258,566	$ 1,258,566	$ 1,258,566				$ 13,684,749
Cumulated grant disbursement requirements			*$ 2,036,939*	*$ 3,055,408*	*$ 3,055,408*	*$ 4,073,878*	*$ 5,218,029*	*$ 5,218,029*	*$ 6,362,180*	*$ 7,506,332*	*$ 7,506,332*	*$ 8,650,483*	*$ 9,909,049*	*$ 9,909,049*	*$ 11,167,616*	*$ 12,426,182*	*$ 13,684,749*	*$ 13,684,749*	*$ 13,684,749*		
Net cashflow primary metric	$ -3,270,398	$ -2,452,798	$ 2,036,939	$ 1,018,469	$ -3,270,398	$ 1,018,469	$ 1,144,151	$ -2,452,798	$ 1,144,151	$ 1,144,151	$ -3,270,398	$ 1,144,151	$ 1,258,566	$ -1,635,199	$ 1,258,566	$ 1,258,566	$ 1,258,566	$ -	$ -		$ -2,667,240
Future value of net cash flow																					
Intermediary IRR	***-24.07%***																				
Cashflows linked to dry-up of capital guarantee (if any)																					*0.0%*
Dry-up of Capital guarantee	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -
Total inflow primary metric + K guarantee	$ -	$ -	$ 2,036,939	$ 1,018,469	$ -	$ 1,018,469	$ 1,144,151	$ -	$ 1,144,151	$ 1,144,151	$ -	$ 1,144,151	$ 1,258,566	$ -	$ 1,258,566	$ 1,258,566	$ 1,258,566	$ -	$ -		$ 13,684,749
Cumulated grant disbursement requirements																					
Net intermediary cashflow	$ -3,270,398	$ -2,452,798	$ 2,036,939	$ 1,018,469	$ -3,270,398	$ 1,018,469	$ 1,144,151	$ -2,452,798	$ 1,144,151	$ 1,144,151	$ -3,270,398	$ 1,144,151	$ 1,258,566	$ -1,635,199	$ 1,258,566	$ 1,258,566	$ 1,258,566	$ -	$ -		$ -2,667,240
Future value of net cash flow																					
Intermediary IRR	***-24.07%***																				
Payments tied to secondary metric																					
Payment for results - Secondary metric		$ -	$ 242,476	$ 242,476	$ -	$ 242,476	$ 242,476	$ -	$ 242,476	$ 242,476	$ -	$ 242,476	$ 242,476	$ -	$ 242,476	$ 242,476	$ 242,476	$ -	$ -		**$ 2,667,240**
Sum of inflows at this stage	$ -	$ -	$ 2,279,415	$ 1,260,946	$ -	$ 1,260,946	$ 1,386,628	$ -	$ 1,386,628	$ 1,386,628	$ -	$ 1,386,628	$ 1,501,043	$ -	$ 1,501,043	$ 1,501,043	$ 1,501,043	$ -	$ -		$ 16,351,988
Cumulated grant disbursement requirements		*$ -*	*$ 2,279,415*	*$ 3,540,361*	*$ 3,540,361*	*$ 4,801,307*	*$ 6,187,934*	*$ 6,187,934*	*$ 7,574,562*	*$ 8,961,190*	*$ 8,961,190*	*$ 10,347,817*	*$ 11,848,860*	*$ 11,848,860*	*$ 13,349,903*	*$ 14,850,946*	*$ 16,351,988*	*$ 16,351,988*	*$ 16,351,988*		
Net intermediary cashflow	$ -3,270,398	$ -2,452,798	$ 2,279,415	$ 1,260,946	$ -3,270,398	$ 1,260,946	$ 1,386,628	$ -2,452,798	$ 1,386,628	$ 1,386,628	$ -3,270,398	$ 1,386,628	$ 1,501,043	$ -1,635,199	$ 1,501,043	$ 1,501,043	$ 1,501,043	$ -	$ -		
Future value of net cash flow																					
Intermediary IRR	***0.00%***																				
Payments tied to third metric																					
Payment for results - Third metric																		750,000			**$ 750,000**
Sum of inflows at this stage	$ -	$ -	$ 2,279,415	$ 1,260,946	$ -	$ 1,260,946	$ 1,386,628	$ -	$ 1,386,628	$ 1,386,628	$ -	$ 1,386,628	$ 1,501,043	$ -	$ 1,501,043	$ 1,501,043	$ 1,501,043	$ 750,000	$ -		$ 17,101,988
Cumulated grant disbursement requirements		*$ -*	*$ 2,279,415*	*$ 3,540,361*	*$ 3,540,361*	*$ 4,801,307*	*$ 6,187,934*	*$ 6,187,934*	*$ 7,574,562*	*$ 8,961,190*	*$ 8,961,190*	*$ 10,347,817*	*$ 11,848,860*	*$ 11,848,860*	*$ 13,349,903*	*$ 14,850,946*	*$ 16,351,988*	*$ 17,101,988*	*$ 17,101,988*		
Net intermediary cashflow	$ -3,270,398	$ -2,452,798	$ 2,279,415	$ 1,260,946	$ -3,270,398	$ 1,260,946	$ 1,386,628	$ -2,452,798	$ 1,386,628	$ 1,386,628	$ -3,270,398	$ 1,386,628	$ 1,501,043	$ -1,635,199	$ 1,501,043	$ 1,501,043	$ 1,501,043	$ 750,000	$ -		
Future value of net cash flow																					
Intermediary IRR	***6.49%***																				
Payments tied to fourth metric																					
Payment for results - Secondary metric																			$ 1,000,000		**$ 1,000,000**
Sum of inflows at this stage	$ -	$ -	$ 2,279,415	$ 1,260,946	$ -	$ 1,260,946	$ 1,386,628	$ -	$ 1,386,628	$ 1,386,628	$ -	$ 1,386,628	$ 1,501,043	$ -	$ 1,501,043	$ 1,501,043	$ 1,501,043	$ 750,000	$ 1,000,000		$ 18,101,988
Cumulated grant disbursement requirements		*$ -*	*$ 2,279,415*	*$ 3,540,361*	*$ 3,540,361*	*$ 4,801,307*	*$ 6,187,934*	*$ 6,187,934*	*$ 7,574,562*	*$ 8,961,190*	*$ 8,961,190*	*$ 10,347,817*	*$ 11,848,860*	*$ 11,848,860*	*$ 13,349,903*	*$ 14,850,946*	*$ 16,351,988*	*$ 17,101,988*	*$ 18,101,988*		
Net intermediary cashflow	$ -3,270,398	$ -2,452,798	$ 2,279,415	$ 1,260,946	$ -3,270,398	$ 1,260,946	$ 1,386,628	$ -2,452,798	$ 1,386,628	$ 1,386,628	$ -3,270,398	$ 1,386,628	$ 1,501,043	$ -1,635,199	$ 1,501,043	$ 1,501,043	$ 1,501,043	$ 750,000	$ 1,000,000		
Intermediary IRR	***13.65%***																				
IVa. Summary																					
Net cashflow with max bonus metric payment	$ -3,270,398	$ -2,452,798	$ 2,279,415	$ 1,260,946	$ -3,270,398	$ 1,260,946	$ 1,386,628	$ -2,452,798	$ 1,386,628	$ 1,386,628	$ -3,270,398	$ 1,386,628	$ 1,501,043	$ -1,635,199	$ 1,501,043	$ 1,501,043	$ 1,501,043	$ 750,000	$ 1,000,000		**$ 1,750,000**
Future value of net cash flow -check																					
Total payment to investors (II + III)	$ -	$ -	$ 2,279,415	$ 1,260,946	$ -	$ 1,260,946	$ 1,386,628	$ -	$ 1,386,628	$ 1,386,628	$ -	$ 1,386,628	$ 1,501,043	$ -	$ 1,501,043	$ 1,501,043	$ 1,501,043	$ 750,000	$ 1,000,000		***$ 18,101,988***
Investor outstanding balance	***$ -3,270,398***	***$ -5,723,196***	***$ -3,443,781***	***$ -2,182,835***	***$ -5,453,233***	***$ -4,192,287***	***$ -2,805,659***	***$ -5,258,457***	***$ -3,871,830***	***$ -2,485,202***	***$ -5,755,600***	***$ -4,368,972***	***$ -2,867,929***	***$ -4,503,128***	***$ -3,002,086***	***$ -1,501,043***	***$ 0***	***$ 750,000***	***$ 1,750,000***		

Annex 11. DIB execution workplan

The launch of the DIB is envisaged end December 2022. This should be feasible by the implementation of the following execution work plan.



The timeline assumes that activities can officially start in early January 2022. It also assumes the dedication of senior resources and prioritization of the DIB project within each participating organization. Indeed, from experience, stakeholder internal negotiations and delays tend to be the main cause of delays in DIB projects.

Based on KOIS's experience in launching impact bonds, risk mitigation measures are envisaged at each step of the feasible timeline as shown below.

Activity	Timeline	Risks	Mitigating measures
Intermediary selection of structuring intermediary	Jan 2022	- Administrative delays	- Prioritization of project by contracting party
Fundraising	Jan-Aug 2022	- Lengthy internal procedures before commitment	- Continue fundraising engagements in Nov. and Dec. 2022 despite uncertainty as to proposal success
Selection of evaluator	Feb.-mid March 2022	- Lack of quality proposals within the budget range	- Invest time in setting the right expectations
Evaluation framework design and parallel design of the financial model	Mid March-July 2022	- Failure to align social investors and outcome funders evaluation targets	- Co-design as soon as possible with social investors and outcome funders to avoid wasting time on modifications at a later stage
Legal drafting	July-Nov. 2022	- Delays due to heavy administrative burden of JP partners or lack of dedicated resources with the appropriate level of expertise - New requirements from DIB parties arising from management changes, etc.	- Transparent & honest sharing of in-house processes and risks by all parties - Address critical clauses and legal constraints of parties upfront to avoid last-minute negotiations - Closely follow activity rollout through regular check-in

Contracts execution	Dec. 2022	- See above	- See above
First disbursement	Jan 2023	- Conditions precedent	- Keep a reasonable time buffer before the hard deadlines
Start of intervention	Jan 2023	- National and regional political circumstances or natural disaster/epidemic beyond the programme's control	- Monitor crises evolution and leave space in the contract for adjustment and adaptation from the programme if they face unexpected events

Annex 12. Fundraising strategy

As evoked elsewhere in this proposal, our fundraising strategy is based on two pillars aimed at minimizing time to success for our very ambitious fundraising:

- Team-based pragmatic approach: (i) transparent sharing of stakeholder knowledge between the UN parties, CIFF, Triggerise and KOIS to create an opportunity list of private and public investors and donors with a known focus either of health, women's empowerment, children or innovative finance; (ii) prioritization and allocation of opportunities based on partners' respective relationship strengths, and shared working document to ensure efficient follow-up and dynamic shifting in priorities, *see extracts below.*

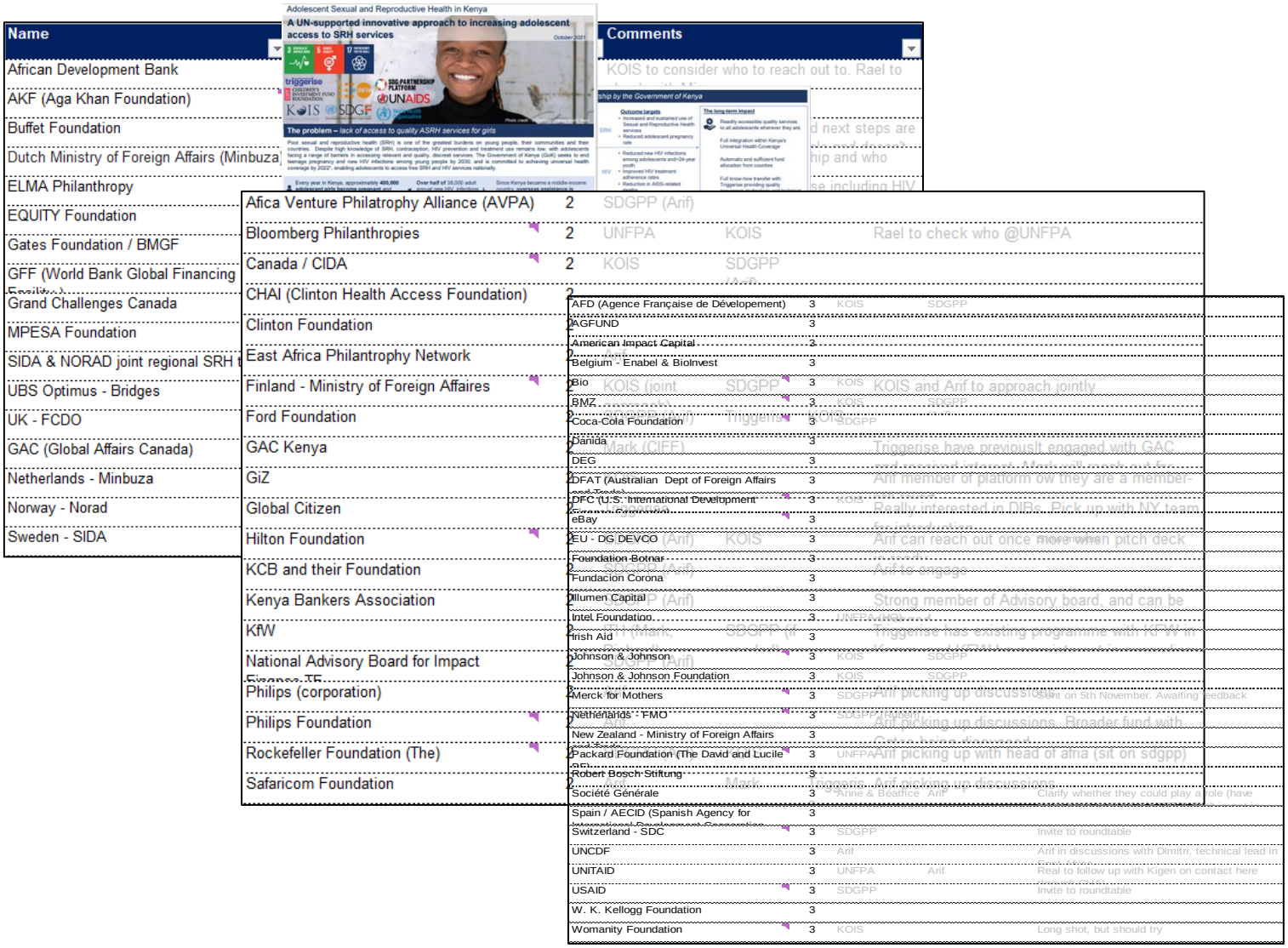
- To preemptively address anticipated challenges, in-depth preparatory work is performed to (i) align the JP parties' respective visions and objectives for the programme and the mechanics of the financial instrument – thereby increasing our conviction power as a team, (ii) develop a high-level financial model that accommodates the investment term requirements (double digit IRR and a preference for capital recycling) of seasoned impact bond investors and will facilitate the participation of straightforward grants to the outcomes funding pool.

Annex 13. Marketing materials

2-pager

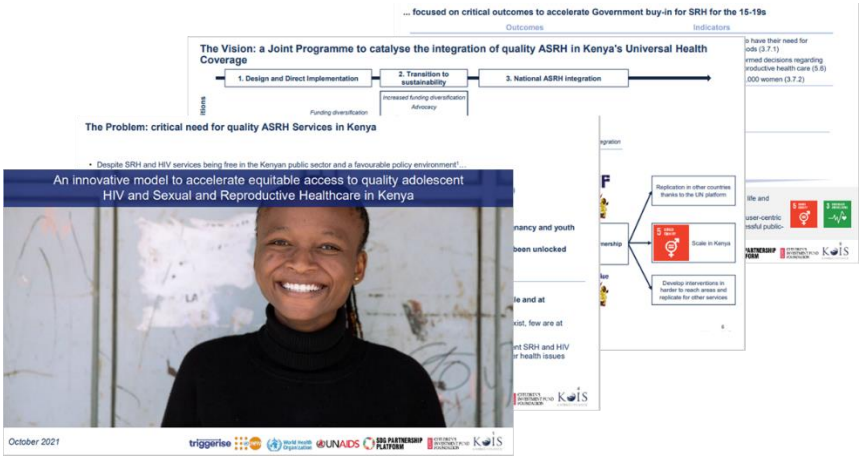
To support stakeholder understanding and engagement, a 2-pager that frames the problem, the solution and highlights essential information of the programme (incl. partners, objectives, the impact bond mechanisms, financials) in a concise and clear manner has been developed.

The 2-pager is disseminated for marketing and fundraising purposes by the JP partners. It is visually appealing and actionable, articulating what is being sought by the partners and how interested parties can proceed for a potential engagement (i.e., contact details).



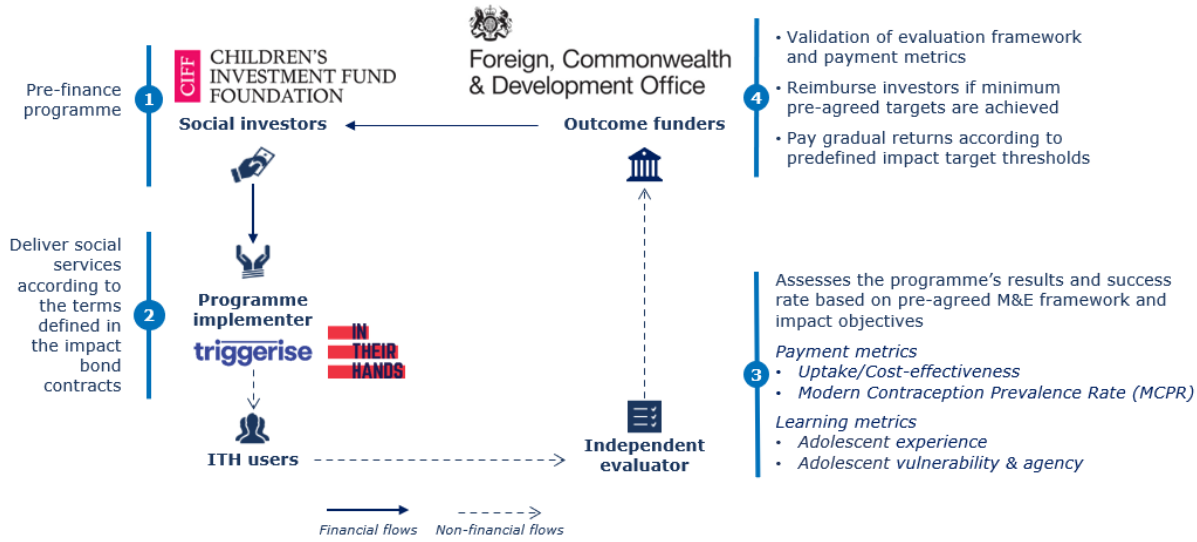
Pitch deck

A pitch deck will be used during the engagement with potential investors. The aim of the pitch will be for the potential investors to fully understand the impact potential of the JP and how their funding can support its development. In other words, the deck effectively articulates who the JP partners are, what the JP aims to achieve, and why the investor should support it. It also details other valuable information such key metrics and financials.



Sample slides from the pitch deck

Annex 14. The First ASRH DIB



CIFF and FCDO entered into a DIB agreement aimed at incentivizing ITH to improve efficacy in delivery while independently measuring the programme's outcomes.

First ASRH DIB terms overview

Duration	18 months
Investment	$6,4m

Outcome payment	$6,8m
Max IRR	3%
Capital guarantee	0%
Capital repayment	100% of the capital repayment is linked to the **number of visits** Evaluation method: monitored on the platform and validated through external audit
Interest payment	100% of the interest payment is linked to **Modern Contraceptive Prevalence Rate** (mCPR) Evaluation method: evaluation by external evaluator 18 months after the launch of the interventions
Learning metrics	Adolescents' experience – monitored on the platform Adolescents' vulnerability and agency

CIFF is a concessional investor comfortable with receiving a limited remuneration compared to the risk taken.

Annex 15. Supporting materials for section 2.6 – Results

Strategies[7]	Indicators	ITH
Promoting the provision of accurate information to prevent early and unintended pregnancies among adolescents	Comprehensive knowledge among adolescents on pregnancy prevention	Yes
	Adolescent CPR	Yes
	Adolescent fertility rate	Yes
Strengthening existing service delivery points for provision of accurate adolescent friendly information and services on pregnancy prevention	Functional adolescent and youth-friendly services (AYFS) facilities	Yes
	Adolescent CPR	Yes
	Adolescent fertility rate	Yes
Strengthening the provision of maternal health services to all pregnant and lactating adolescents, including the marginalized and vulnerable adolescents	Facility readiness to provide adolescent-youth-friendly services	Yes
	Adolescents using ANC, skilled birth delivery, PAC and PNC services	Yes
Promotion of male engagement in prevention of early and unintended pregnancy	Adolescent CPR	Yes
	Adolescent fertility rate	Yes
	Age at first sex among males aged 10–19	No

[7] Strategies to address early and unintended pregnancy as defined by the National ASRH Policy 2017–2021 by the Kenya Ministry of Health

Promotion of school re-entry of adolescent mothers	School enrolment and transition rate among girls	Yes
Strengthening inter-sectorial coordination for effective prevention of early and unintended pregnancy	Functional multi-sectorial ASRH TWGs at national and county levels	Yes

Leaving no girl behind

Triggerise uses youth-centred design principles, so that the diverse needs of these different groups of adolescents, are at the core of programme design and delivery.

Triggerise uses youth-centred design principles, so that the diverse needs of these different groups of adolescents are at the core of programme design and delivery. The ITH concept, messaging, branding and technology were prototyped and tested with Kenyan adolescent girls before being piloted with a range of different adolescent groups. Today, daily user insights from the platform, alongside routine data collection, and user feedback allows ITH to track progress and course-correct in order to respond to user needs in real time.

Triggerise recognizes that the digital transformation in health is both an opportunity and a risk that can exacerbate inequality and as such offers supported pathways to platform engagement, utilizing community mobilizers to reach girls without a phone. Triggerise also works with community-based organizations targeting the most marginalized groups, such as adolescents living with HIV, those at risk of sexual violence, and girls in age-disparate relationships.

Triggerise and the JP work with families, community leaders and with national champions to listen, discuss and engage so that girls living in poverty are supported throughout their ITH journey. Triggerise delivers facilitated sessions in communities, sponsored by local leaders, on the risks of unprotected sex, unplanned pregnancy and relationship with community resilience and prosperity. For this project Triggerise will also work with public health facilities to promote adolescent friendly ASRH and HIV services filling the gaps to ensure that no girl is left behind.

Annex 16. Letters of support

Letter of Support 1: Bridges Outcomes

28th October 2021

Dear SDG Fund Team,

We are writing this letter to express our interest as a potential provider of investment to the projected second ASRH Kenya Development Impact Bond in the context of the Joint Programme: '[An innovative model to accelerate equitable access to quality adolescent HIV and Sexual and Reproductive Healthcare in Kenya]'.

The SDG Outcomes Investment Fund is a new fund to support outcomes contracts in developing countries, jointly established by Bridges Outcomes and the UBS Optimus Foundation. The fund is committed to creating better outcomes for people and better value for outcomes payers. It will do so through helping create direct and systemic impact by providing c. $100m of investment for outcomes-focused projects mainly focused on health, education, employment and the environment, with a gender lens, and by supporting the creation of enabling ecosystem which supports collaborative, flexible and accountable delivery.

Following early conversations with some of the Joint Programme's parties and first analysis of the indicative project model and terms, we believe the DIB could be aligned with our Fund's impact and return goals. We appreciate the innovative nature of In Their Hands' implementation model and the Joint Programme's ambition to strengthen it for the ultimate objective of integration in Kenya's public health response.

Alignment with the project would need to be confirmed during the DIB's design phase – to which we would be keen to contribute through co-creation with all involved stakeholders, including delivery partners, funders, investors and ideally individuals who would be using this service. Confirmation of our interest is also crucially dependent on the successful completion of our due diligence of Triggerise and the proposed intervention, and verification of In Their Hands' track record.

We understand that, with the current iteration of design, the programme's 3-year implementation budget to be circa $16m, to be financed through investment commitments of $8m, recycled after 18 months-depending on the success level at that stage. With all the caveats here above, we believe a (recyclable) investment commitment in the $3m-5m range could be feasible.

Our commitment would be subject to the results of the co-design process, due diligence on partners and agreement of terms under the final investment structure.

Please reach out should you have any questions.

Sincerely,

Mila Lukic
Director, SDG Outcomes Fund

Letter of support 2: CIFF

CHILDREN'S INVESTMENT FUND FOUNDATION

29th October 2021

To:
Benoit Renard
CEO and Co-Founder

Triggerise

Workshop 17, The Watershed
17 Dock Road
Cape Town, 8002
South Africa

www.triggerise.org

Dear Benoit,

This communication is in relation to your enquiry regarding The Children's Investment Fund Foundation ("CIFF") being a potential "Investor" in the proposed second ASRH Kenya Development Impact Bond (the "Proposed DIB"), where Triggerise will play the role of "Implementer" and UN FPA the role of anchor "Outcomes Funder".

The Proposed DIB relates to the wider In Their Hands ("ITH") programme which looks to accelerate equitable access to quality adolescent HIV and Sexual and Reproductive Healthcare in Kenya, and of which CIFF is the founding donor. We understand that the Proposed DIB is subject to UN FPA being successful in its application for funding to the UN Joint SDG Fund.

Having considered your DIB proposal – which we note at this stage, is an initial high-level proposal with the specific terms and conditions to be determined in conjunction with the Outcomes Funder and other outcome funders and investors, should UN FPA's application be successful – we are able to provide an initial in-principle (and legally non-binding) indication of our interest in playing the role of Investor through this letter of support. This support is based primarily on the fact that the Proposed DIB is supporting Impact outcomes that align with CIFF's own charitable objectives, as well as our confidence in Triggerise's ability to effectively play the role of Implementer.

This letter of support is subject to (but not limited to) the following conditions[1]:

A. Successful selection of UN FPA's application for funding from the UN Joint SDG Fund (which provides a proportion of the total outcomes funding required)
B. Securing the additional outcomes funding commitments needed for the Proposed DIB (including evaluation cost)
C. CIFF would in no event commit more than one third of the total Investor funding
D. Securing the additional Investor funding needed for the Proposed DIB
E. Automatic and prompt repayment of CIFF's invested capital plus an annualised rate of return of no less than 2.9%, over the duration of the DIB (including the evaluation period) should outcome KPIs be achieved and independently verified
F. Agreement on investment terms with all parties, including but not limited to:
    I. Acceptable outcome KPIs for payment and verification or measurement thereof
    II. Drawdown amounts, schedules, and conditions
    III. Payment amounts and schedules

[1] Please note that this is not an exhaustive list and is based only on the limited information available to us at this time. Further conditions may arise as the terms and conditions of the Proposed DIB become clearer, and as CIFF completes its due diligence (commercial, legal and tax).

CHILDREN'S INVESTMENT FUND FOUNDATION

IV. Counterparty defaults

This Letter nor any verbal communications in connection with it, do not constitute or imply a commitment by CIFF or any related party, to provide any funding to ITH, nor a representation that such funding will be made available. Any such commitment is subject to contract, credit committee approval and satisfactory due diligence and documentation. Nothing in this letter shall affect any rights or obligations between the parties under any existing funding arrangement or grant as at the date of this Letter. For the avoidance of doubt, the status of existing funding arrangements between CIFF and ITH will be relevant to any decision by CIFF to participate in the Proposed DIB as an Investor.

The contents of this Letter and any verbal communications in connection with it shall be treated as confidential save where express consent to disclosure is provided by CIFF in advance.

This letter will expire on the earlier of the date of entry into any Proposed DIB by CIFF or June 30, 2022.

This Letter and any non-contractual rights or obligations that are claimed in relation to it shall be governed by English law.

.

Please reach out should you have any questions.

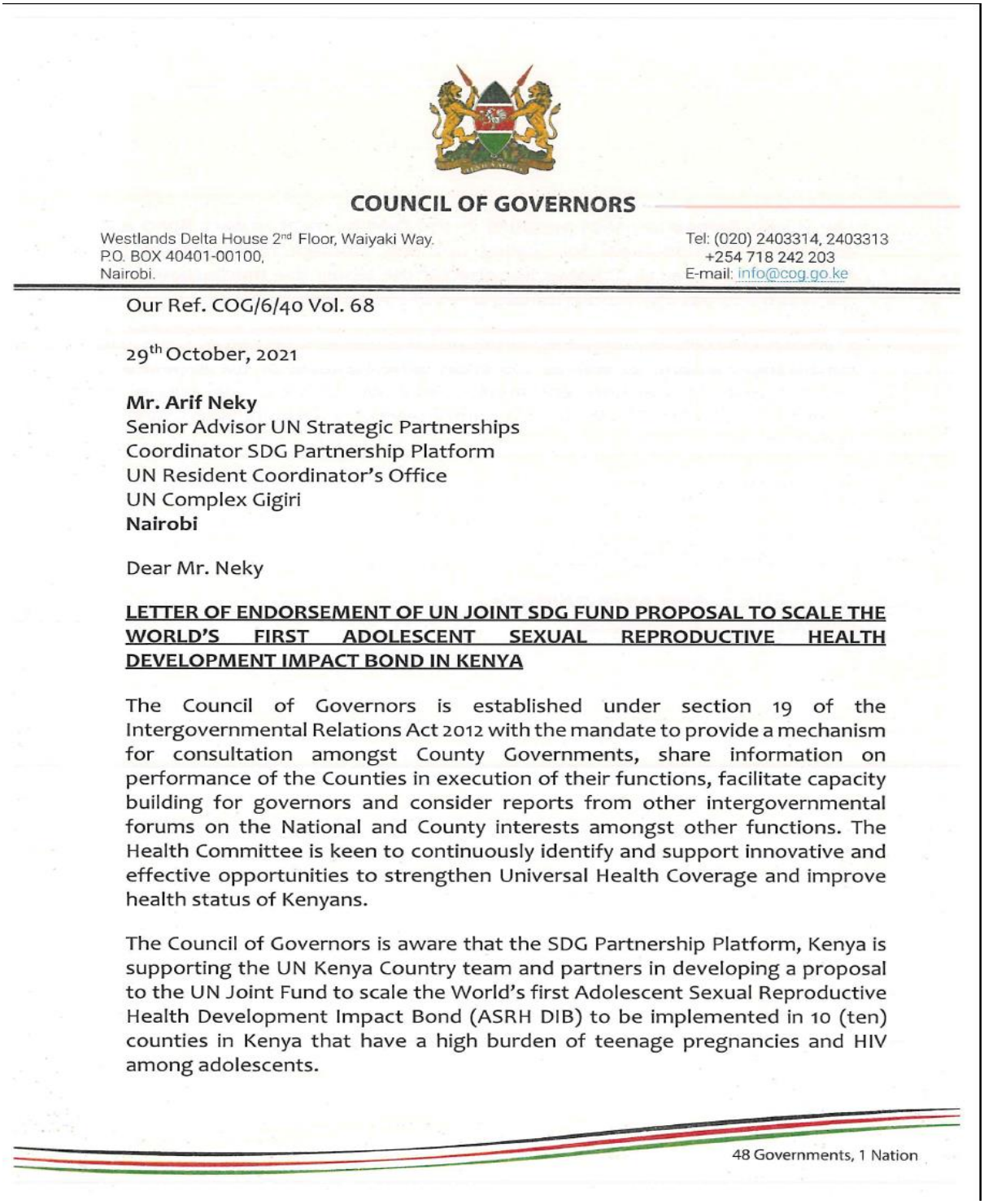
Yours Sincerely,

DocuSigned by:
Imraan Mohammed
EC4573F36ECF435...

Imraan Mohammed

Head of Impact Investing
Children's Investment Fund Foundation

Letter of Support 3: Council of Governors



COUNCIL OF GOVERNORS

Westlands Delta House 2nd Floor, Waiyaki Way.
P.O. BOX 40401-00100,
Nairobi.

Tel: (020) 2403314, 2403313
+254 718 242 203
E-mail: info@cog.go.ke

Our Ref. COG/6/40 Vol. 68

29th October, 2021

Mr. Arif Neky
Senior Advisor UN Strategic Partnerships
Coordinator SDG Partnership Platform
UN Resident Coordinator's Office
UN Complex Gigiri
Nairobi

Dear Mr. Neky

LETTER OF ENDORSEMENT OF UN JOINT SDG FUND PROPOSAL TO SCALE THE WORLD'S FIRST ADOLESCENT SEXUAL REPRODUCTIVE HEALTH DEVELOPMENT IMPACT BOND IN KENYA

The Council of Governors is established under section 19 of the Intergovernmental Relations Act 2012 with the mandate to provide a mechanism for consultation amongst County Governments, share information on performance of the Counties in execution of their functions, facilitate capacity building for governors and consider reports from other intergovernmental forums on the National and County interests amongst other functions. The Health Committee is keen to continuously identify and support innovative and effective opportunities to strengthen Universal Health Coverage and improve health status of Kenyans.

The Council of Governors is aware that the SDG Partnership Platform, Kenya is supporting the UN Kenya Country team and partners in developing a proposal to the UN Joint Fund to scale the World's first Adolescent Sexual Reproductive Health Development Impact Bond (ASRH DIB) to be implemented in 10 (ten) counties in Kenya that have a high burden of teenage pregnancies and HIV among adolescents.

The Health Committee sees potential in the Development Impact Bond and appreciates the potential for scaling not only through replication of the instrument to cover all Counties but also for the innovative mechanism to be utilised to address other underfunded areas of social development.

In line with the collaboration that the Council of Governors has had with the SDG Partnership Platform as well as the great understanding of the impact and benefits that the Development Impact Bond would bring, the Council of Governors endorses the UN Kenya Country team and partners in this funding opportunity.

Yours sincerely

H. E Hon. Prof. Peter Anyang Nyong'o
Chairman, Health Committee

Letter of support: Bungoma County

REPUBLIC OF KENYA

COUNTY GOVERNMENT OF BUNGOMA
MINISTRY OF HEALTH
OFFICE OF THE COUNTY EXECUTIVE
COMMITTEE MEMBER

Telephone: 055-30343
Cell: 0722 - 516779
E-mail: antotwalela@gmail.com
Our Ref: CG/BGM/MOH/CEC/PARTINERS/VOL 1(68)

County Executive Offices
Fifth Floor
P.O. BOX 437, BUNGOMA
29th October, 2021

Dear Dr, Rael,

RE: ADOLESCENT SEXUAL REPRODUCTIVE HEALTH PROGRAMME - LETTER OF COMMITMENT

Bungoma county is one of the counties that have reported very high numbers of teenage pregnancies in the last few years. KDHS 2014 placed the county at 14% in terms of teenage pregnancy rates, Performance Monitoring for Action reported the county at 17% with a significant 3% increase in 2020.Statistics for the first half of 2021 indicate an upward trend, this is compounded by events surrounding the Covid 19 pandemic The county government endeavours to continue implementing interventions to mitigate the negative trend in collaboration with like- minded partners and welcomes the proposed initiative aimed at contributing towards ending adolescent pregnancies, new HIV infections and AIDS related deaths among adolescent girls in the county.

The Department of Health Services is pleased to confirm financial and in-kind contribution of Ksh.10,000,000 for Human resource and county co-ordination, Ksh.5,000,000 for medical supplies and Ksh.5,000,000 for programme related costs such as capacity building, media engagement and baseline survey towards the programme over the three-year period.
The Department of Health Services, Bungoma County, further commits to provide leadership and ensure that there is a supportive environment for the programme implementation across the three years for successful delivery of the set outcomes in alignment with the Ministry of Health policies and guidelines.

We look forward to being part of this innovative programme as we all strive to give the Bungoma girl a formidable foundation for a prosperous future.

Yours Sincerely,

COUNTY EXECUTIVE MEMBER
FOR HEALTH
BUNGOMA COUNTY
P. O. Box 437-50200, BUNGOMA

Dr. Anthony Walela
County Executive Committee Member
Health and Sanitation
BUNGOMA COUNTY

Scanned with CamScanner

Letter of Support: Kisumu County

InREPUBLIC OF KENYA

COUNTY GOVERNMENT OF KISUMU

Telegrams: "PRO (MED)"
Tel: 254-057-2020105
Fax: 254-057-2023176
E-mail: kisumucoh@gmail.com

Chief Officer of Health & Sanitation.
P.O. Box 721 – 40100,
Kisumu.

DEPARTMENT OF HEALTH & SANITATION

Our Ref: GN 133 VOL. IX (429) **Date:** 28th October, 2021

Dear Dr. Stephen Jackson,

Re: Adolescent Sexual Reproductive Health Programme - Letter of Commitment

This is in response to your letter dated 25th October 2021 on the above subject.

Kisumu County welcomes the proposed initiative aimed at contributing towards ending adolescent pregnancies, new HIV infections and AIDS related deaths among adolescent girls in the county.

The Department of Health Services is pleased to confirm financial and in-kind contribution of Ksh 44,524,.000 towards the programme over the three-year period. The value of the contribution will encompass costs of staff, medical supplies and programme related costs such as coordination and quality assurance *and technical support*

The Department of Health Services, Kisuumu County, further commits to provide leadership and ensure that there is a supportive environment for the programme implementation across the three years for successful delivery of the set outcomes in alignment with the Ministry of Health policies and guidelines and Kisumu County Heath Strategic and Investment plan.
We look forward to being part of this innovative programme that will improve Adolescent Sexual reproductive Health in Kisumu County

Sincerely,

Dr. G. Ganda
Chief Officer Health and Sanitation,
KISUMU.

Letter of Support: Kisii County

KISII COUNTY GOVERNMENT
OFFICE OF THE EXECUTIVE COMMITTEE MEMBER
HEALTH SERVICES

Telegramme "Medical"
Telephone: 0702 560 801
Fax: (058) 31310
E-Mail: sarah.omache@kisii.go.ke/
pacepbs@yahoo.com

Kisii Level 5 Hospital
P.O. Box 92 – 40200,
KISII – KENYA.

When replying quote
REF: KCG/CECH/PART/VOL. 2/96

29th October, 2021

UN Resident Coordinator, Kenya
P.O. Box 30218, 00100
NAIROBI

Dear Dr. Stephen,

ADOLESCENT SEXUAL REPRODUCTIVE HEALTH PROGRAMME - LETTER OF COMMITMENT

Kisii County Government, Department of Health Services welcomes the proposed initiative aimed at contributing towards ending adolescent pregnancies, new HIV infections and AIDS related deaths among adolescent girls in the county.

The Department of Health Services is pleased to confirm financial and in-kind contribution of Ksh. 21,800,000.00 towards the programme over the three-year period. The value of the contribution will encompass costs of staff, medical supplies and programme related costs such as coordination and quality assurance.

The Department of Health Services, Kisii County, further commits to provide leadership and ensure that there is a supportive environment for the programme implementation across the three years for successful delivery of the set outcomes in alignment with the Ministry of Health policies and guidelines.

We look forward to being part of this innovative programme.

Sincerely,

KISII COUNTY GOVERNMENT
EXECUTIVE COMMITTEE MEMBER
HEALTH SERVICES
P.O. BOX 92-40200, KISII

MRS. SARAH OMACHE, HSC
CEC – HEALTH SERVICES
KISII COUNTY GOVERNMENT

Letter of Support: Kakamega County

REPUBLIC OF KENYA

COUNTY GOVERNMENT OF KAKAMEGA
MINISTRY OF HEALTH SERVICES

Telephone: 056-31850/1852/31853
Email: health@kakamega.go.ke
Website: www.kakamega.go.ke
When replying please quote
Ref No: CGK/MOH/CEC/ADM.1/VOL.III (23)

The Executive Committee Member
P.O. Box 36-50100
KAKAMEGA

Date: 28th October, 2021

Dr. Stephen Jackson,
UN Resident Coordinator, Kenya

RE: ADOLESCENT SEXUAL REPRODUCTIVE HEALTH PROGRAMME - LETTER OF COMMITMENT

The matter under caption refers.

Adolescent pregnancies, HIV infections and AIDS related deaths have been on the rise among adolescent girls in Kakamega County. Although measures have been put in place to mitigate the situation, inadequate funding continues to hamper effective implementation. It is for this reason that the County Government of Kakamega through the Department of Health Services welcomes the proposed initiative aimed at eliminating early pregnancies, new HIV infections and AIDS related deaths among adolescent girls in the county.

As a government, we are pleased to confirm financial and in-kind contribution of **Kshs. 250 Million** towards the programme over the three-year period. The value of the contribution will encompass costs of staff, medical supplies and programme related costs such as coordination and quality assurance. We further commit to provide leadership and a supportive environment for the programme implementation across the period for the successful delivery of the set outcomes in tandem with the Ministry of Health policies and guidelines.

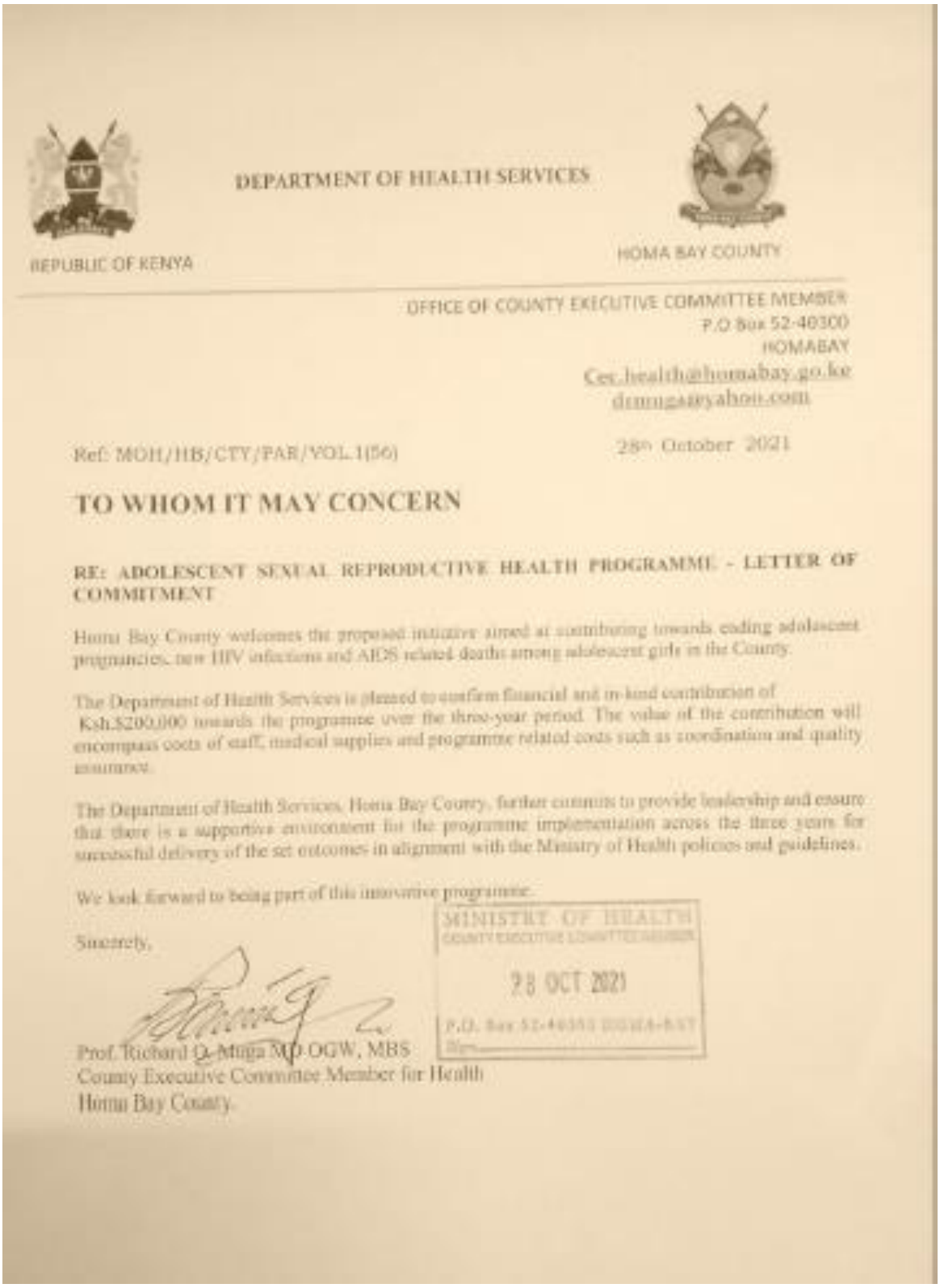
We look forward to partnering with you in this innovative programme.

EXECUTIVE COMMITTEE MEMBER
MINISTRY OF HEALTH SERVICES
COUNTY GOVERNMENT OF KAKAMEGA
P. O. Box 359, KAKAMEGA - 50100

Collins K. Matemba, Ph.D.
County Executive Committee Member, Health Services

Copy: 1. H.E. the Governor, Kakamega County
2. CECM- Finance, Economic Planning and ICT
3. Chief Officer, Health Services

Letter of Support: Homabay County



DEPARTMENT OF HEALTH SERVICES

REPUBLIC OF KENYA

HOMA BAY COUNTY

OFFICE OF COUNTY EXECUTIVE COMMITTEE MEMBER
P.O Box 52-40300
HOMABAY
Cec.health@homabay.go.ke
dmuga@yahoo.com

Ref: MOH/HB/CTY/PAR/VOL.1(56)

28th October 2021

TO WHOM IT MAY CONCERN

RE: ADOLESCENT SEXUAL REPRODUCTIVE HEALTH PROGRAMME - LETTER OF COMMITMENT

Homa Bay County welcomes the proposed initiative aimed at contributing towards ending adolescent pregnancies, new HIV infections and AIDS related deaths among adolescent girls in the County.

The Department of Health Services is pleased to confirm financial and in-kind contribution of Ksh.5200,000 towards the programme over the three-year period. The value of the contribution will encompass costs of staff, medical supplies and programme related costs such as coordination and quality assurance.

The Department of Health Services, Homa Bay County, further commits to provide leadership and ensure that there is a supportive environment for the programme implementation across the three years for successful delivery of the set outcomes in alignment with the Ministry of Health policies and guidelines.

We look forward to being part of this innovative programme.

Sincerely,

MINISTRY OF HEALTH
COUNTY EXECUTIVE COMMITTEE MEMBER
28 OCT 2021
P.O. Box 52-40300 HOMA-BAY

Prof. Richard O. Muga MD OGW, MBS
County Executive Committee Member for Health
Homa Bay County.

Letter of Support: Mombasa County

DEPARTMENT OF HEALTH SERVICES
Date 29th October 2021

Dear Dr. Stephen Jackson,

Re: Adolescent Sexual Reproductive Health Programme - Letter of commitment

Mombasa County welcomes the proposed initiative aimed at contributing towards adolescent pregnancies, new HIV infections and AIDs related deaths among adolescents in County.

County welcomes the proposed initiative aimed at contributing towards ending adolescent pregnancies, new HIV infections and AIDS related deaths among adolescent girls in the county *(Adjust as relevant)*

The Department of Health Services is pleased to confirm financial and in-kind contribution of Ksh. 13,722,000 towards the programme over the three-year period. The value of the contribution will encompass costs of staff, medical supplies and programme related costs such as coordination utility bills and quality assurance

The Department of Health Services, County, further commits to provide leadership and ensure that there is a supportive environment for the programme implementation across the three years for successful delivery of the set outcomes in alignment with the Ministry of Health policies and guidelines .

We look forward to being part of this innovative programme.

Sincerely,

Celina Kithinji
County GBV/Adolescent Health Program Coordinator
Signing On behalf of,

Dr. Godfry Nato
CEC Health
Mombasa County

Letter of Support: Migori County

REPUBLIC OF KENYA

COUNTY GOVERNMENT OF MIGORI
DEPARTMENT OF HEALTH SERVICES

Telegrams: "MOH", Migori
Telephone:
Email: cecm.health@migori.go.ke
When replying please quote

COUNTY EXECUTIVE COMMITTEE MEMBER
MIGORI COUNTY
P O BOX 1865-40400
SUNA - MIGORI

Ref: No. MIG/MOH/CEC/ADM/Vol I/921.

26th October, 2021.

The Coordinator,
UN Resident, Kenya.

Att: Dr. Stephen Jackson.

Dear Sir/Madam,

RE: ADOLESCENT SEXUAL REPRODUCTIVE HEALTH PROGRAMME - LETTER OF COMMITMENT

Migori County welcomes the proposed initiative aimed at contributing towards ending adolescent pregnancies, new HIV infections and AIDS related deaths among adolescent girls in the county.

The Department of Health Services is pleased to confirm financial and in-kind contribution of Ksh. 10,000,000 towards the programme over the three-year period. The value of the contribution will encompass costs of staff, medical supplies and programme related costs such as coordination and quality assurance.

The Department of Health Services, Migori County, further commits to provide leadership and ensure that there is a supportive environment for the programme implementation across the three years for successful delivery of the set outcomes in alignment with the Ministry of Health policies and guidelines.

We look forward to being part of this innovative programme.

Thank you.

Yours faithfully,

C.E.C. MEMBER, HEALTH SERVICES MIGORI COUNTY
26 OCT 2021
P.O. Box 1865-40400, SUNA MIGORI

Lt Col(Rtd)Joseph Nyaoke
County Executive Committee Member.
MIGORI COUNTY.
Cell: 0722326754
Email : [redacted]

Scanned with CamScanner

Letter of Support: Treasury

REPUBLIC OF KENYA
THE NATIONAL TREASURY AND PLANNING

Telegraphic Address: 22921
Finance – Nairobi
FAX NO. 318833
Telephone: 2252299
When Replying Please Quote

THE NATIONAL TREASURY
P O BOX 30007 - 00100
NAIROBI

Ref: MOF/ERD/1/11/D TY

Date: 30th March 2020

Siddharth Chatterjee
UN Resident Coordinator to Kenya
Office of the Resident Coordinator in Kenya
United Nations Avenue
P. O. Box 30218 - 00100
Nairobi

Dear Sidd,

RE: ENDORSEMENT OF UN JOINT SDG PROPOSALS

Thank you for your letter seeking for endorsement for the UN Kenya Country Team to submit two proposals to the joint UN SDG Fund.

As you know, the National Treasury is strengthening its policy and instruments to finance the delivery of the Sustainable Development Goals in Kenya, including through catalyzing strategic investments. The proposals you are submitting for advancing adolescent reproductive health and catalyzing strategic investments in the agriculture sector are in line with the Government of Kenya's big four agenda. Both proposals are also aligned with the GOK – UN development Co-operation Framework (2018 – 2022).

Consequently, your request is well received and is supported by the National Treasury & Planning.

Kindly keep me abreast of the process moving forward.

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I thank you and the UN Kenya Country Team for the support to Kenya's development agenda.

Yours sincerely,

HON. (AMB) UKUR YATANI, EGH
CABINET SECRETARY/NATIONAL TREASURY AND PLANNING

Letter of Support: AVPA

25/11/2020

To: Arif Neky
Coordinator, SDG Partnership Platform
UN Resident Coordinator's Office
P.O. Box, 30218-00100
UN Complex, Gigiri
Nairobi,
Kenya.

RE: UN JOINT SDG FUND PROPOSAL TO SCALE WORLD'S FIRST ADOLESCENT SEXUAL & REPRODUCTIVE HEALTH DEVELOPMENT IMPACT BOND IN KENYA

In response to our interesting discussion regarding the above proposal, this is to affirm our interest and full support of the AFRICA VENTURE PHILANTHROPY NETWORK (AVPA) to engage further with you and your team to jointly identify opportunities for private sector engagement and investments as you seek to scale the world's first Adolescent Sexual and Reproductive Health (ASRH) Development Impact Bond (DIB) in Kenya.

We acknowledge the various sexual and reproductive health challenges faced by adolescents and youth and AVPA have just introduced a gender platform with a health and safety community of practice to ensure that every female adolescent realizes their full potential towards nation building and fulfilling their full potential.

As AVPA, we look forward to the continued collaboration with the UN ASRH DIB joint team, as well as the other partners (CIFF, ITH and its implementing partners), all convened by the SDG Partnership Platform as we explore opportunities to advance this innovative financing instrument for health, and work towards delivering ASRH services; as part of our broader UHC agenda in Kenya.

Yours Sincerely,

Frank Aswani
CEO AVPA

Letter of Support: KEPSA

KENYA PRIVATE SECTOR ALLIANCE FOUNDATION

2nd Floor, Shelter Afrique Building,Mamlaka Rd.
Phone: +254 20 2730371|2|2727936|883
Mobile: +254 720 340949|735 999979
Fax: +254 20 2730374
Email: info@kepsa.or.ke, http://www.kepsa.or.ke

25/11/2020

Arif Neky,
Coordinator, SDG Partnership Platform
UN Resident Coordinator's Office
P O Box 30218 – 00100
UN Complex, Gigiri
Nairobi, Kenya

RE: UN JOINT SDG FUND PROPOSAL TO SCALE WORLD'S FIRST ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH DEVELOPMENT IMPACT BOND IN KENYA

In response to our interesting discussion regarding the above proposal, this is to affirm the interest and full support KEPSA Foundation to engage further with you and your team to jointly identify opportunities for private sector engagement and investment as you seek to scale the world's first Adolescent Sexual and Reproductive Health (ASRH)Development Impact Bond in Kenya.

We acknowledge the various sexual and reproductive health challenges faced by adolescents and youth, and have been implementing several strategic interventions to ensure that every adolescent realizes their full potential towards nation building.

The UN Joint SDG Fund proposal addresses the issues of teenage pregnancies and new HIV infections among young people, and also highlights the importance of generating ASRH data for informed decision making and harnessing partnerships. This is in line with four priority areas and actions stipulated in the National Adolescent Sexual Reproductive Health Policy (2015) which includes reducing early and unintended pregnancy, reducing STIs including HIV, increasing access to ASRH information and age appropriate comprehensive sexuality education, and promoting Adolescent Sexual Reproductive Health and Rights (ASRHR).

As the KEPSA Foundation, we look forward to continued collaboration with the UN ASRH DIB joint team, as well as the other partners (CIFF, ITH and its implementing partners), all convened by the SDG Partnership Platform as we explore opportunities to advance this innovative financing instrument for health, and work towards delivering ASRH services as part of our broader UHC agenda in Kenya.

Yours sincerely,

Chairman, KEPSA Foundation