

**End Evaluation of GoK/UNFPA
8th Country Programme 2014-2018**

**Final Submission to UNFPA Kenya
Country Office**

August 2017

MAP of Kenya



Consultant Team

Position and Role	Name
Team Leader	Helen Jackson
Sexual and Reproductive Health; Adolescents and Youth	Dan Onyango-Maina
Gender Equality and Women's Empowerment	Jane Kiragu
Population Dynamics	Martin Wanjohi

Acknowledgements

The evaluation team would like to extend our warm thanks to UNFPA for the opportunity to undertake this end evaluation of the GoK/UNFPA 8th Country Programme 2014-2018. We greatly appreciated the support and guidance of the evaluation manager in particular, and also the support of all staff who generously gave their time and energy to facilitate the process. We appreciated the presentations made to the consultants on the various areas of the programme and implementation framework at the beginning of the evaluation, which greatly facilitated consultant engagement. Our thanks to the officer in charge and the assistant representative who approved and contributed to this approach, and to the operations management staff for their assistance in generating the requisite graphs from the electronic system. Our thanks also to the administrative staff who competently facilitated logistics and other practical support essential to the smooth running of the evaluation.

In addition, we would like to express our gratitude to all stakeholders in government, the international development community, implementing partners, private sector organisations and beneficiaries for their willingness to meet us and contribute their knowledge and insights, and also for the additional documentation they could provide.

We also extend our appreciation to the Evaluation Reference Group, including the regional ESARO monitoring and evaluation specialist, who contributed valuable comments to both the design report and the evaluation report, enabling us to improve their quality and substance, and to the stakeholders who contributed to quality assurance of the evaluation report.

Table of Contents

Map of Kenya	i
Acknowledgements	ii
Abbreviations and Acronyms	iv
Tables and Figures	vi
Key Facts Table	vii
Structure of the Evaluation Report	ix
Executive Summary	x
1. Introduction	1
1.1 Purpose and Objectives of the Country Programme Evaluation	1
1.2 Scope of the Evaluation	1
1.3 Methodology and Process	2
2. Country Context	7
2.1 Development Challenges and National Strategies	7
2.2 The Role of External Assistance	12
3. UNFPA Response and Programme Strategies	14
3.1 UN and UNFPA Response	14
3.2 UNFPA Response through the Country Programme	14
4. Findings	22
4.1 Evaluation Question 1: Relevance, Responsiveness and Strategic Alignment	22
4.2 Evaluation Question 2: Effectiveness	25
4.3 Evaluation Question 3: Efficiency	42
4.4 Evaluation Question 4: Added Value and Sustainability	48
5. Conclusions	53
5.1 Strategic Level	53
5.2 Programmatic Level	54
6. Recommendations	58
6.1 Strategic Level	58
6.2 Programmatic Level	59
6.3 Lessons Learned	62
Annexes	
Annex 1	Terms of Reference
Annex 2	Persons Met and Institutions
Annex 3	Documents Consulted
Annex 4	Evaluation Matrix
Annex 5	Research Instruments
Annex 6	List of Atlas Projects
Annex 7	Results and Resources Framework
Annex 8	Implementation Rate

Abbreviations and Acronyms

ACCAF	Africa Coordinating Centre for the Abandonment of FGM/C
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APR	Annual Programme Report
ARP	Alternative Rite of Passage
ART	Antiretroviral Therapy
ASD	Age of sexual debut
ASRH	Adolescent Sexual and Reproductive Health
AWP	Annual Work Plan
C4C	Choice4Change
CCA	Common Country Assessment
CG&E	Commission on Gender and Equality
CHW	Community Health Workers
CIFF	Children's Investment Fund Foundation
CO	Country Office
COAR	Country Office Annual Report
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CRD/S	Civil Registration Department / Services
CSO	Civil Society Organisation
CSPro	Census and Survey Processing
DANIDA	Danish International Development Assistance
DAO	Delivering as One
DD/DemDiv	Demographic Dividend
DfID	Department for International Development (UK)
DHIS	District Health Information System
DPHK	Development Partners for Health in Kenya
EM	Evaluation Manager
EmNOC	Emergency Neonatal and Obstetric Care
EmOC	Emergency Obstetric Care
EMTCT	Extensive Elimination of Mother to Child Transmission
EQ	Evaluation Question
EQA	Evaluation Quality Assessment
ERG	Evaluation Reference Group
ESARO	East and Southern Africa Regional Office (UNFPA)
ET	Evaluation Team
FBO	Faith Based Organisation
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
FIDA Kenya	Federation of Women Lawyers Association Kenya
FP	Family Planning
FSW	Female Sex Workers
GBV	Gender Based Violence
GDP	Gross Domestic Product
GEWE	Gender Equality and Women's Empowerment
GoK	Government of Kenya
HACT	Harmonised Approach to Cash Transfers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IMIS	Integrated Multisectoral Information System
ICPD POA	International Conference on Population and Development Programme of Action
IMR	Infant Mortality Rate
IP	Implementing Partner
KAIS	Kenya AIDS Indicator Survey
KASF	Kenya AIDS Strategic Framework
KDHS	Kenya Demographic and Health Survey

KHF	Kenya Healthcare Federation
KI	Key Informant
KNBS	Kenya National Bureau of Statistics
KPHS	Kenya Population and Housing Survey
KSPA	Kenya Service Provision Assessment
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MED	Monitoring and Evaluation Directorate
mCPR	Modern (methods) Contraceptive Prevalence Rate
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MoH	Ministry of Health
MTP	Medium Term Plan
MTR	Mid-Term Review
NACC	National AIDS Control Council
NaiLab	Nairobi Incubation Lab
NASCOP	National HIV/AIDS and STI Control Programme
NCPD	National Council for Population and Development
NEPHAK	National Empowerment Network of People Living with HIV/AIDS
NGO	Non-Government Organisation
ODPP	Office of the Director of Public Prosecution
PD	Population Dynamics
PSHP	Private Sector Health Partnership
PSRI	Population Studies and Research Institute
PoA	Programme of Action
RBM	Results Based Management
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
PMTCT	Prevention of Mother to Child HIV Transmission
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
RRF	Results and Resources Framework
SDGs	Sustainable Development Goals
SDP	Service Delivery Point
SRA	Strategic Results Area
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNESCO	United Nations Education, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNHCR	United Nations Humanitarian and
UNICEF	United Nations Children Fund
UN-RCO	United Nations Resident Coordinator's Office
UNST	United Nations Statistical Team
USAID	United States Agency for International Development
WHO	World Health Organization

Tables and Figures

Tables

Table 1.1 Targets, Tools and Approaches

Table 1.2 Limitations and Mitigation Responses

Table 1.3 Timelines for Key Tasks and Deliverables after Preparation Phase of CPE

Table 3.1: 7th CP Programme Areas, Outcomes and Outputs

Table 3.2: UNFPA Kenya Response through the Country Programme

Table 4.2.1 Summary Achievements Table for Sexual and Reproductive Health

Table 4.2.2 Summary Achievements Table for Adolescents and Youth

Table 4.2.3 Summary Achievements Table for Gender Equality and Women's Empowerment

Table 4.2.4 Summary Achievements Table for Population Dynamics

Table 4.3.1 Outline of Reporting and Quality Assurance Activities in the UNFPA CO

Figures

Figure 2.1 Kenya's Population Pyramid

Figure 3.1: GoK/UNFPA 8th CP Intervention Counties

Figure 3.2 Summary of Budget vs Expenditure for the 8th CP to Mid 2017

Figure 3.3 Budget and Expenditure by Programme Area and Year from mid 2014

Figure 3.4 Budget and Expenditure by Origin of Funds, mid 2014 to mid 2017

Figure 4.1 The UNFPA Bull's Eye

Key Facts Table for Kenya

Land	
Geographical location	East Africa
Land area	580,609 sq. km. ¹
People	
Population (2017)	47.9 million (KPHS 2009 ²)
Urban /Rural Population	32% / 68% (KPHS 2009)
Population growth rate	2.9% (KPHS 2009)
Government	
Type	Democratic Republic
Key political events	Independence from colonial power in 1963 Promulgation of the Constitution 2010
Economy	
GDP per capita 2011 PPP USD	2,901 ³
GDP growth rate	5.8% ⁴
Main Economic Activity	Agriculture
Social Indicators	
Human development index, rank	0.555, 146 ⁵
Unemployment (Total 15-24 years)	22% ⁶
Life expectancy and birth, Male / Female (years)	58 / 61 ⁷
Under 5 mortality (per 1000 live births)	52% (KDHS 2014 ⁸)
Maternal mortality (deaths of women per 100,000 live births)	362 (KDHS 2014)
Births attended by skilled health personnel (%)	62% (KDHS 2014)
Health Expenditure (as a % of GDP)	3.5% (2014) ⁹
Contraceptive prevalence rate (modern methods)	53%
Unmet need for family planning (% of currently married women, 15-49 years)	18% (KDHS 2014)
Literacy (% aged 15 – 49 years)	92% men, 87.8% women (KDHS 2014)
Proportion of women aged 15-19 years who have already began childbearing	18.1% (KDHS 2014)
People living with HIV, 15-49 years (%)	1.6 million (KAIS 2012)
HIV Prevalence rate, 15-49 years (%)	5.6% (KAIS 2012)
HIV prevalence, 15-24 years: Male/Female (%)	2.1% (KAIS 2012)

Sustainable Development Goals (SDGs) Status	Indicator and source	Status ¹⁰
Goal 2. End hunger, achieve food security and improved nutrition, and promote sustainable agriculture	Proportion of children under 5 years who are underweight (KDHS 2014)	11%
	Proportion of under 5 years severely underweight (KDHS 2014)	2%
Goal 3. Ensure healthy lives and promote well-being for all at all ages	Maternal mortality ratio (per 100,000 live births) (KDHS 2014)	362
	Births attended by skilled health personnel (KDHS 2014)	62%

¹ Kenya National Bureau of Statistics

² Kenya National Bureau of Statistics, population projection based on Kenya Population and Housing Survey, 2009

³ World Bank - <http://data.worldbank.org/indicator/NY.GDP.PCAP.PP.KD>

⁴ Kenya National Bureau of Statistics, Economic Survey 2016

⁵ UNDP, Human Development Report 2016,

⁶ <http://data.worldbank.org/indicator/SL.UEM.1524.MA.ZS?locations=KE>

⁷ Kenya National Bureau of Statistics, Statistical Abstract 2016

⁸ Kenya National Bureau of Statistics, Kenya Demographic and Health Survey, 2014

⁹ <http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS?locations=KE>

¹⁰ Data available in mid 2017

	Antenatal care coverage (KDHS 2014)	90%
	Infant mortality rate (per 1,000 live births) (KDHS 2014)	39
	Under 5 years mortality rate (per 1,000 live births) (KDHS 2014)	52
	HIV prevalence among general population	5.6
	HIV prevalence among 15-24 year olds (KDHS 2014)	2.9%
	Level of comprehensive knowledge about HIV among 15-24 yr olds (KDHS 2014)	60.9%
	Proportion of adult population infected with HIV accessing ARVs (KDHS 2014)	78%
	Proportion of children under 5 years who slept under ITN ¹¹ (KDHS 2014)	54%
	Proportion of pregnant women who slept under ITN (KDHS 2014)	51%
	TB prevalence rate (per 100,000) (KDHS 2014)	300
	TB case detection and treatment (under DOTS Strategy) (KDHS 2014)	88%
	Contraceptive prevalence rate (KDHS 2014)	58%
	Unmet need for family planning (KDHS 2014)	18%
Goal 4. Ensure inclusive and equitable quality education and promote life-long learning opportunities for all	Primary school net enrolment rate (NER) (ES 2017)	89.2%
	Proportion of pupils completing primary school (ES 2017)	83.5%
	Primary to secondary transition rate (ES 2017)	81.3%
	Secondary school NER (ES 2017)	51.3%
	Ratio of girls to boys in primary school (ES 2017)	0.98
	Ratio of girls to boys in secondary school (ES 2017)	0.89
	Ratio of girls to boys in TIVET institutions (ES 2017)	0.65
	Ratio of girls to boys in private universities (ES 2017)	0.89
	Ratio of girls to boys in public universities (ES 2017)	0.67
	Literacy rates of 15-24 year olds (KDHS 2014)	94.4%
	Literacy level among men aged between 15-49years (KDHS 2014)	97%

¹¹ Insecticide Treated Mosquito Net

	Literacy level among women aged between 15-49 years (KDHS 2014)	88%
Goal 5. Achieve gender equality and empower all women and girls	Proportion of seats held by women in the National Assembly (ES 2017)	19.8%
	Proportion of seats held by women in the Senate (ES 2017)	26.9%
Goal 7. Ensure access to affordable, reliable, sustainable, and modern energy for all	Proportion of electricity generated from renewable sources (ES 2017)	85%
Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	Annual GDP Growth (ES 2017)	5.8%
	Mobile money subscriptions (CAK 2017)	27.5m
Goal 9. Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation	Mobile penetration rate (CAK 2017)	86.2%
	Internet / data penetration rate (CAK 2017)	89.4%

Structure of the Country Programme Evaluation Report

The Evaluation Report is structured according to the UNFPA Evaluation Handbook.¹² The first chapter introduces the purpose and objectives of the country programme evaluation, outlines its scope, and presents the methodology and overall process. The second chapter provides the country context, indicating the main development challenges and national strategies, followed by the role of external assistance (both overseas development aid and the United Nations Development Assistance Framework). The UN and UNFPA response is outlined in the third chapter, including both the previous UNFPA country programme and the present one (the 8th Country Programme). This chapter also includes the financial structure of the programme. The fourth chapter provides the findings for all evaluation questions for the four programme areas and the strategic positioning and implementation framework of the country office including for monitoring and evaluation. Finally, the fifth and sixth chapters provide conclusions, recommendations and lessons learned from the evaluation.

Prior to the main chapters the report includes acknowledgements, acronyms and abbreviations, the list of tables and figures, a key facts table and an executive summary. Finally, the report provides the following annexes: terms of reference, the list of persons met and institutions, the documents that the team consulted, the evaluation matrix, research instruments, the list of Atlas projects, the results and resources framework and the full financial implementation rate.

¹² UNFPA, Independent Evaluation Office. How to Design and Conduct a Country Programme Evaluation at UNFPA, October 2013 as revised in July 2016. New York.

Executive Summary

1. Purpose of the Country Programme Evaluation, July 2014 to June 2017

The purpose of the country programme evaluation (CPE) was to examine UNFPA accountability to stakeholders in achieving development results, use of resources, and to assist evidence-informed decision making to guide the 9th country programme. The evaluation was commissioned by the UNFPA Country Office (CO) in Kenya in line with standard procedure. The target audience is UNFPA from country to headquarters level, the evaluation reference group and network, and key stakeholders.

2. Evaluation Objectives and Country Programme (CP) Outline

The overall objectives¹³ were to assess the relevance and contribution of the CP to national development results, to enhance the accountability of UNFPA and the Kenya Country Office (CO), and to generate a set of clear, forward-looking, actionable recommendations logically linked to findings and conclusions.

More specifically, the CPE aimed to assess: 1) progress on achieving the expected outputs and outcomes of the results framework; 2) the strategic positioning of the CO and its capacity to respond to national needs and add value to development results; 3) how far the implementation framework enabled or hindered achievements of the results chain; and 4) the CO monitoring and evaluation system. Focal areas also included relevance and responsiveness, efficiency, effectiveness, sustainability of results, coordination and partnerships, office typology, financial and management systems, and assessment of the integration of human rights and gender.

The CP has four thematic areas: sexual and reproductive health, adolescents and youth, gender equality and women's empowerment, and population dynamics, with a priority focus to strengthen national and county level institutional capacity.

3. Methodology

Overall, the CPE has five phases. First the CO engaged an evaluation reference group (ERG), established terms of reference and recruited the four-person consultant team. The next three phases were evaluation design, data capture and analysis, and development of the draft report and presentations for the CO, the ERG and stakeholders. The fifth phase is final quality assurance and UNFPA management response.

The consultants utilized a participatory methodology fully in line with the revised UNFPA Handbook. First this involved developing a design report describing the evaluation and presenting the stakeholder selection, evaluation matrix and tools for approval by the CO and ERG, as well as a brief country situation and response analysis and outlines of the previous and present country programmes. Second, the evaluation team undertook data capture, analysis and triangulation utilizing extensive document review, field visits, semi-structured key informant interviews in the office and with stakeholders drawn from the full range of partners, and focus group discussions with beneficiaries. The draft evaluation report was presented to the CO and to the ERG and revised for presentation to stakeholders and ultimately for sending to headquarters for final comments for consultant inclusion. Despite challenges in some stakeholder follow up (e.g. a nurses' strike), the purpose and objectives of the CPE were fully met with good CO support.

4. Main Conclusions

The **strategic conclusions** of the evaluation are that the CP is fully aligned to international and national commitments and priorities and has shown responsiveness to changing circumstances (such as the Kenya lower middle income country status and humanitarian needs). During the CP the CO gained a reputation for high level advocacy and high visibility (although visibility is reported to be declining),

¹³ Terms of Reference for the GoK/UNFPA 8th Country Programme 2014-2018 Evaluation

and succeeded in considerable resource mobilization, with a strong staff complement built to address specific needs. Innovative private-public partnerships were developed and the CO has been a highly respected and trusted partner within UNDAF and delivering as one. Office efficiencies were strengthened for financial management and monitoring and evaluation, and within-office communications appear strong within and between teams. Across all programmes the technical capacity of the CO was rated highly.

Overall achievement of activities and interventions across the programmes was generally high, with contributions to national policies and strategies the most significant together with support for specific projects, and demand creation the least well established and measured. The implementation rate of expenditures against budgets was high overall and was at an acceptable level.

UNFPA added value and contributed to national ownership and sustainability of results across the programmes, particularly through contributions to policies, strategies and plans across the areas of its mandate, to national county and local capacity building, and to resource mobilization.

Main challenges included: 1) The CP supported a large number of activities and multiple implementing partners across the programme areas, which will not be sustainable, and that was not necessarily the most strategic approach to contribute optimally to high level outcomes and impacts; 2) Although there was strong support for the generation of population data and for research in the various programmes, dissemination and use of evidence to inform policy and programme were insufficient; 3) a rights based approach was insufficiently articulated and gender mainstreaming was not always evident; 4) demand creation fell short of intended results; 5) the results chain logic was not always sufficiently robust across the programme, impeding measurement of some results.

For the **sexual and reproductive health** component the CO successfully leveraged resources and public-private partnerships to work with the UN H6 partners to support government to develop a dynamic and comprehensive reproductive, maternal, neonatal, child and adolescent health (RMNCAH) project targeting six priority counties (selected as they bear the burden of 50 percent of maternal mortality in Kenya). This increased the availability of infrastructure and equipment, coverage and utilisation of a skilled continuum of care, and advocacy efforts contributed to prioritisation of RMNCAH at national and county government level. The CO was also a valued partner advocating the integration of SRH and GBV into the wider humanitarian response, supporting family planning commodity security and demand creation, and in addressing obstetric fistula through treatment camps. On HIV, CO support went to key populations, adolescents and young people and to national condom programming through the development of policy documents and scale-up of service delivery for female sex workers. **Main challenges:** Inadequate resource allocation impeded community mobilization efforts for SRH demand creation; and the training camps to address obstetric fistula proved expensive and unlikely to be sustainable, with services under-utilised largely because of stigma. Challenges also continue with the devolved system of health care to counties (e.g. regarding financing, and county level RH commodity forecasting and quantification, leading to stock-outs); and industrial action by health staff impeded implementation efforts in 2016 and 2017.

In the **adolescent and youth** component, capacity development among youth networks achieved some success, and the CO found that digital and online platforms reach large numbers of young people with SRH information. The CO also contributed through policy support and advocacy to an innovative project (Choice4Change) to increase family planning uptake particularly by adolescent girls nationally and in UNFPA core counties. A recent evaluation will indicate the achievement of results. The CO contribution for adolescent and youth also included support for age appropriate sexuality education in schools and many other activities with diverse implementing partners, including support for policy and strategy development and research. **Main challenges:** Demand creation efforts for SRH services, including for HIV counselling and testing, were insufficient, a situation exacerbated by high resistance to the planned integration of age appropriate comprehensive sexuality education in schools.

The **gender equality and women's empowerment** component focused on gender based violence (GBV) and female genital mutilation/cutting (FGM/C). It achieved its targets around advocacy, coordination and capacity development at national and county levels with a variety of activities to address the main interventions. The CO contributed to the establishment and support of GBV networks to increase discourse on socio-cultural norms and to promote the implementation of laws and policies on GBV to which it had contributed in the previous CP. The CO also introduced a gender marker to assess interventions and their likely cost benefits. This was not effectively utilised although it was clearly articulated in GEWE and in the focus on vulnerable groups including adolescents and youth, sex workers, teen mothers, SRH/GBV in humanitarian situations. **Main challenges:** It remains a long-term challenge to change deep-seated gender norms and traditions such as FGM/C and to reduce GBV, and current efforts are insufficiently coordinated and robust. Poor use of the gender marker impedes effective tracking of results.

In **population dynamics** considerable support has been provided for data capture, assisting the key government counterparts achieve national and county level surveys and other products, and starting preparation for the 2019 census. **Main challenges:** Funding limitations affected some planned activities, including late disbursements. Dissemination of data in appropriate formats to reach diverse users was also underfunded and insufficient, and the use of population data in different sectors of development for policy, planning and programme implementation remains inadequate. Although support was provided to strengthen national and county capacity, including for M&E, this did not achieve the needed impact, particularly at county level. Further concerns remain regarding national and county level coordination and ownership, slow upscaling of good practice and sustainability.

5. Main Recommendations

At the **strategic level**, the 9th CP needs to align to the upcoming international and national frameworks, (e.g. the 2030 agenda for the Sustainable Development Goals and the Quadrennial Comprehensive Policy Review at international level and the Mid Term Plan 111 of Kenya Vision 2030). Across all programme areas, the CP needs to focus on upstream activities of advocacy, innovative resource mobilization, knowledge management, strategic partnerships and catalytic technical assistance rather than direct support for multiple local-level activities. The CP also needs to act on lessons learned from current interventions to support a smaller number of strategic IPs and programmes, given extreme inequality in the country. The policy environment is largely in place but the CO should engage where policy and strategy development is still required at national and county level, continue to build national and county capacities, and invest in effective approaches to disseminate new policies and frameworks. The CPD requires stronger results chain logic to measure strategic outputs to address outcomes. The office typology will need to be restructured and streamlined according to the strategic direction of the next CP.

The main recommendations for **SRH**, within the framework of upstream approaches (as above) are to: develop a comprehensive demand creation strategy aligned to strengthened service provision, taking into account the needs of the most vulnerable; evaluate the RMNCAH project to assess lessons learned in order to streamline the project model and to inform potential scale up; support interventions to address family planning commodity stock-outs; support the scale up and linkage of SRH and GBV interventions in humanitarian situations; and to promote integration of obstetric fistula management within routine SRH service delivery, improved multi-sectoral coordination, fistula data management and community mobilization to create demand. A specific output on HIV is needed to facilitate monitoring and tracking of HIV prevention interventions and results.

The main recommendations for the **adolescent and youth SRH** component are to: develop an advocacy and stakeholder engagement plan to address CSE in schools; scale up digital platforms to reach adolescents and youth; design programmes to reach parents on adolescent sexuality; promote multisectoral approaches to address adolescent health issues, particularly regarding teen pregnancy and HIV; continue to build the meaningful engagement of young people at all levels of adolescent and youth planning; and to leverage support to scale up the youth and gender friendliness of health facilities and promote community outreach to generate demand.

The main recommendations for the **gender equality and women's empowerment** component are to: strengthen both capacity for transformative community dialogues and collaboration between key actors for GBV and FGM/C; to develop a risk and mitigation strategy to address GBV, FGM/C and wider gender inequalities with a strong advocacy campaign; campaign to transform social norms; adopt an integrated approach for the FGM/C, early marriages, GBV interventions with UNFPA's SHR and adolescent and youth programmes; and ensure the capacity to utilize the gender marker effectively to guide strategic planning and programming.

UNFPA should strengthen its support for **population dynamics**. This is a key added value for the UN to achieve not just data capture but effective dissemination of information and technical support for the use of data by national and county government counterparts and other stakeholders at all levels, including communities. The main recommendations are to: provide sufficient investment in refocusing effort on dissemination and capacity building for the effective use of data; support the strengthening of M&E institutional capacities at both levels of government and particularly at county level; address data needs in humanitarian situations; and mobilize resources to operationalise key information systems.

Lessons Learned

Some key lessons learned from the 8th CP evaluation are:

1. High level lobbying and timely advocacy by the CO based on strategic evidence leveraged significant financial resources and national and county commitment to reduce maternal mortality, and support wider sexual and reproductive health needs.
2. Continued advocacy at different levels, based on continued generation and use of strategic information, and stronger branding are needed to ensure UNFPA retains visibility that is currently declining.
3. With declining international resources it is not strategic and sustainable for the CO to continue to support multiple local implementing partners and local activities. Lessons should be learned from current pilots and other efforts to inform future advocacy, resource mobilization and appropriate technical support.
4. By supporting strategic partnerships, including innovative public-private partnerships and exploring emerging financial opportunities, the CO helped to galvanise the comparative advantage of diverse sectors and generated new opportunities for development.
5. The CO has utilised a critical and focused evidence base on the most vulnerable geographical areas and populations successfully to leverage resource commitment targeted to where it is most needed.
6. Greater CO investment is needed to strengthen access to, understanding and strategic use of information throughout all sectors in order to ensure that the generation of evidence and data leads to evidence-informed policy, planning, programme implementation and monitoring and evaluation.
7. The CO has focused on building national and local capacity for strategic planning, implementation, monitoring and evaluation for output, outcome and impact results. This is an ongoing requirement that needs efficient and effective technical assistance and financial resources, and clear understanding of present resources and responses.

Chapter One: Introduction

1.1 Purpose and Objectives of the Country Programme Evaluation

The **purpose** of the country programme evaluation (CPE) was to:

- ❖ Demonstrate the accountability of UNFPA to all its stakeholders regarding how well it achieved development results and its use of invested resources
- ❖ Assist evidence-informed decision making
- ❖ Facilitate learning to help guide the 9th country programme.

The evaluation was commissioned by the UNFPA Country Office in Kenya in line with standard procedure. There was no mid-term review of the country programme.

The overall **objectives**¹⁴ were to:

1. Assess the relevance and contribution of the CP to national development results
2. Enhance accountability of UNFPA and the Kenya Country Office (CO), and
3. Generate a set of clear forward-looking and actionable recommendations logically linked to the findings and conclusions. These recommendations include specific guidance on the development of the 9th country programme. Lessons learned from the 8th CP are also highlighted.

More specifically, the CPE aimed to¹⁵:

1. Provide an independent assessment of the progress of the programme towards achieving the expected outputs and outcomes set forth in the results framework of the country programme document (CPD)
2. Provide an assessment of the positioning of the CO within the development community and in relation to national partners, examining its ability to respond to national needs while adding value to the country development results
3. Assess the extent to which the implementation framework enabled or hindered achievements of the results chain, i.e. what worked well and what did not work well
4. Assess the CO monitoring and evaluation system.

1.2 Scope of the Evaluation

To address the aims above, the evaluation assessed progress on the outputs and outcomes of the four thematic areas of the 8th CP: sexual and reproductive health; adolescents and youth; gender equality and women's empowerment, and population dynamics. In addition, the CPE explored cross-cutting issues within the programmes, notably a human rights based approach and gender mainstreaming.

The CPE explored the strategic positioning and relevance of the CO, the sustainability of its achievements, its added value, coordination roles and partnerships, and its capacity to respond to changing national needs. It reviewed the implementation framework, exploring the office typology, efficiencies and effectiveness. This included the monitoring and evaluation (M&E) system, how it is implemented and utilised, and how well it captures critical data to assess programme implementation.

The evaluation took place from 8 May to 29 July 2017 and covered the planned and implemented interventions of the 8th CP from 2014 to mid-2017 (to the extent possible). Geographically it covered the counties of Homa Bay, Kilifi and Nairobi (Kasarani/Ruaraka

¹⁴ Terms of Reference for the GoK/UNFPA 8th Country Programme 2014-2018 Evaluation

¹⁵ *ibid.*

sub-county) that have UNFPA-implemented interventions. The evaluation also reviewed the flagship trust fund project Improving Maternal and Neonatal Outcomes in Six High Burden Maternal Mortality Counties in Kenya. This reproductive, maternal, neonatal, child and adolescent health (RMNCAH) project Phase 1 was implemented between July 2015 and December 2016 in six counties, Migori, Isiolo, Wajir, Marsabit, Lamu and Mandera.

1.3 Methodology and Process

1.3.1 Methodology

The CPE followed standard evaluation criteria drawn from the United Nations Evaluation Group (UNEG)/Organization for Economic Cooperation and Development (OECD), and as stipulated in the ToR (Annex 1). The 8th CP was assessed in relation to relevance, effectiveness, efficiency, sustainability, added value, corporate strategic alignment, and responsiveness. The cross-cutting themes of human rights, gender mainstreaming within the work of UNFPA, and synergies between programme areas were also relevant. The evaluation team refined the key evaluation questions developed by the ERG and evaluation manager as presented below. The questions relate to each technical programme area and also to CO strategic positioning, management and structure. These were explored in relation to a set of assumptions that are highlighted in the Evaluation Matrix (Annex 4).

EQ1: Strategic Alignment, Relevance and Responsiveness

- a. To what extent is the country programme aligned with: ICPD, MDGs and SDGs, and to the core strategy of UNFPA?
- b. To what extent is the country programme aligned with national laws, policies, needs and stakeholder priorities? How far has the CO responded to changes in national needs and priorities or major political shifts?
- c. How far did the CO respond to recommendations from the 7th CP?
- d. How effectively does the CO coordinate with other UN agencies to deliver as one, particularly in areas of potential overlap?

EQ2: Effectiveness

- a. To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? How adequate was the theory of change underlying the results chain logic?
- b. To what extent has the programme integrated the cross-cutting issues of gender and human rights based approaches?
- c. Were there any unforeseen consequences of the UNFPA programme?

EQ3: Efficiency

- a. To what extent has UNFPA made good use of its human, financial and technical resources to pursue the achievement of the outputs and outcomes defined in the country programme?
- b. To what extent are results effectively and efficiently measured and contributing to accountability in programming?

EQ4: Added value and sustainability

- a. What is the added value of UNFPA in Kenya in relation to other stakeholders and to the achievement of results?
- b. To what extent have UNFPA-supported interventions contributed to capacity development in its implementing partners and communities?
- c. How far has UNFPA successfully promoted national ownership regarding its programme areas (policies, increased capacity and budgetary allocation)?

CO management and the ERG reviewed the evaluation matrix, tools and questions to ensure their relevance, appropriateness and comprehensiveness, and to assure the quality and usefulness of the evaluation to guide the way forward in the 9th CP. Their recommendations were taken into account in finalising the design report prior to the fieldwork that began after the design report was approved. Minor amendments were made to the evaluation questions during data analysis so as to improve reporting flow.

Data collection and analysis

The CPE was a participatory process that actively involved UNFPA staff and key stakeholders. To ensure robust analysis and understanding of the programme logic, underpinned by the theory of change, the evaluation adopted several data collection methods and systematically triangulated data from different sources. Annex 2 provides the list of stakeholders reached for interview or focus group discussion (FGD). Stakeholder selection followed the UNFPA Handbook guidelines for sexual and reproductive health and for adolescents and youth. Regarding gender equality and women’s empowerment and population dynamics, the number of IPs was small enough to allow the evaluators to include all.

Document review formed the backbone of the evaluation, and Annex 3 presents the full list of documents consulted. The extensive document review was supplemented by primary data from: key stakeholder interviews with CO staff, government, international development partners, private sector and civil society organisations (implementing partners, IPs); focus group discussions with primary and secondary beneficiaries; field visits and observation. Fieldwork took place at national and county levels, and both quantitative and qualitative data were collected, analysed and triangulated.

Key informant interviews had semi-structured interview schedules based on the key evaluation questions, assumptions to be tested and indicators, and were adapted to the specific area under review. Likewise, the FGDs involved semi-structured schedules adapted to the specific primary or intermediary beneficiary group. Data were cleaned and compiled, and subject to content, contribution and/or trend analysis as appropriate. Site visits allowed for direct observation of selected IP programmes and projects, adding further richness to the overall data. Where data were conflicting, the consultants attempted to seek further clarification. They have indicated in the report where findings are insufficiently robust to draw firm conclusions. The following table indicates the application of the above data collection methods.

Table 1.1 Targets, Tools and Approaches

Target	Tool and approach
UN including UNFPA CO, international development partners, government, private sector, implementing partners	Key informant semi-structured interview schedules, document review, brief additional questionnaires
Beneficiaries, some IP staff	Focus group discussion (FGD) guide
Field visits to project and programme sites	Observation checklist, KI interviews, beneficiary FGDs, document review

Contribution analysis identified how far documented inputs and activities are likely to have contributed to outputs and outcomes. This required exploration of the theory of change in the results chain logic and of both the sufficiency and relevance of the inputs and activities to achieve outputs and to contribute to outcome results. The linked trend analysis explored the change in results over time in quantitative indicators in the CP and, where possible in qualitative results.

Throughout, the team benefitted from regular contact and discussion with the evaluation and programme managers, and with financial and administrative staff to clarify issues and contribute to validation.

1.3.2 Limitations encountered during the CPE

Table 1.2 highlights limitations and risks encountered during the CPE and the mitigation responses.

Table 1.2 Limitations and Mitigation Responses

Limitations and Risks	Mitigation Responses
Team leader on board over a week after the national consultants, making it challenging to meet the original timelines for the design report.	Comprehensive presentations and orientation provided by CO to team members, with presentations and selected documents sent to the team leader. Optimal allocation of areas of responsibility for design report, and extension of timelines.
Non-availability of some stakeholders, or follow up in document provision. Some beneficiaries unavailable (nurses' strike and closure of facilities during fieldwork), logistical problems	The ET was as flexible as possible regarding dates for KI interviews, extending fieldwork, and making repeated attempts at follow up to minimise loss. They also held some interviews with alternatives from the institution where the lead could not be reached, and investigated different sources to gain essential documents. Beneficiaries were met to the extent possible.
Most sites for RMNCAH, in particular the Mandera pilot centre, could not be visited for security and other reasons (time, logistics)	Review of documents and national KI interviews plus FGD and questionnaire with county officers from all RMNCAH counties; visits to two of the six counties.

None of the limitations was sufficient to invalidate the evaluation, and the team is confident that a wide, sufficiently representative range of stakeholders was reached at national and county levels. Most important, the team visited all three counties, Homa Bay, Kilifi and Kasarani/Ruaraka that UNFPA is supporting (beyond the RMNCAH) and two RMNCAH counties. Focus group discussions were held with some primary beneficiaries, adolescent males and females, and sex workers, and some secondary beneficiaries (such as law enforcement officers).

1.3.3 Evaluation process

The evaluation process followed the UNFPA CPE Handbook.¹⁶ The consultants utilised the Evaluation Quality Assessment Grid (EQA), Norms and Standards of the UN Evaluation Group (UNEG) and the Ethical Code of Conduct for UNEG/UNFPA Evaluations. There were five phases as outlined below.

Phase 1: Preparation. Led by the evaluation manager with support from others in the CO, this involved: developing terms of reference; establishing the evaluation reference group (ERG); and recruiting the consultants (undertaken by the operations team). It also involved identification of key documents for reference by the evaluation team.

Phase 2: Design phase (developing the design report). The evaluation team (ET) was oriented to the CO and the evaluation and, with critical guidance and assistance from the evaluation manager (EM): undertook desk review, stakeholder mapping and stakeholder selection for interview, focus group discussions (FGDs) and site visits; developed the evaluation matrix, finalising evaluation questions and all research instruments; and agreed a schedule for data collection and analysis and a work plan for the field and synthesis phases of the evaluation. The final design report incorporated feedback from the CO, the ERG (including the monitoring and evaluation adviser in ESARO).

¹⁶ Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA. Independent Evaluation Office. October 13. Revised Template 13, July 2016.

Phase 3: Fieldwork. Utilizing and continuing the document review from Phase 2, the ET undertook key informant (KI) interviews, FGDs with beneficiaries and site visits as determined in the stakeholder selection. This phase allowed for testing and refinement of the evaluation matrix and tools and involved preliminary documentation of findings.

Phase 4: Reporting phase. The ET undertook data cleaning, collation, triangulation and analysis, developing the draft and final evaluation reports and presenting them for critique and validation. The CO and ERG reviewed the draft report, and the EM consolidated the feedback for the consultants to address. The ET then revised the report and made a presentation to the ERG and CO and then, after incorporating further feedback, to stakeholders. This iterative process allowed for repeated clarification and validation of the findings, conclusions, recommendations and lessons learned.

Phase 5: Dissemination and follow up. This involves ESARO and UNFPA headquarters followed by final consultant inputs to incorporate their comments. Then the EM and the CO prepare a management response to the recommendations of the evaluation for ESARO and headquarters.

The consultants collaborated on tasks throughout the evaluation. After the completion of the design report, the three national specialists focused on their thematic areas while the lead consultant evaluated the full implementation framework and strategic positioning, as well as contributing extensively to drafting and editing, providing quality assurance for the entire report and trouble-shooting as needed.

The evaluation manager ensured that all resource and logistical requirements for the consultancy were fully met at every stage, especially with regards primary data collection, and provided advice and support as required throughout the evaluation process. Programme specialists, as well as the evaluation manager, assisted with stakeholder mapping and selection.

The three thematic consultants began work on 8th May, and the lead consultant on 18th May 2017, with stakeholder presentation on 28th July 2017. The key tasks and deliverables after full consultant engagement are presented in Table 1.3. The design stage included stakeholder mapping and selection and preparation by the CO and consultants for the coming fieldwork.

Table 1.3 Timelines for Key Tasks and Deliverables after Preparation Phase of CPE

DELIVERABLES	WEEKS										
	1	2	3	4	5	6	7	8	9	10	11
Orientation, desk review, design report and tools	x	x	x								
Submission of design report, CO/ERG review		x	x	x							
Approval of finalised design report				x							
Data collection, consolidation and analysis				x	X	x					
Analysis, triangulation, drafting of report					X	x	x	x			
Ist draft report and powerpoint presentation to CO & ERG								x			
Incorporate comments and submit to ERG								x	x		
Present to ERG, CO									x		
Incorporate feedback, present to stakeholders										x	
Incorporate stakeholder feedback and submit final report											x
Final draft of report submitted for ESARO and HQ review											x
Incorporate comments and submit final evaluation report after receipt of feedback from ESARO/HQ											

The next steps after submission of the draft evaluation report included quality assurance from the CO and ERG prior to presentation to the stakeholders for further comments and then final

quality assurance by ESARO and UNFPA headquarters. Once all revisions are complete and the report is accepted by UNFPA, the CO makes a management report to ESARO and headquarters, the overall quality of the report is assessed and the consultants are informed of the ultimate rating of the evaluation report. Finally, the report is packaged for distribution within UNFPA and among stakeholders in Kenya and internationally, while being utilised to help guide the development of the next country programme from August onwards.

Chapter Two: Country Context

2.1. Development challenges and national strategies

2.1.1 Country context overview

Kenya is located in eastern Africa, bordered by Tanzania to the south, Uganda and Lake Victoria to the west, Ethiopia to the north, Somalia to the northeast, South Sudan on the northwest and the Indian Ocean to the east.¹⁷ Thus it borders two states facing humanitarian crises, with Kenya taking in high numbers of refugees and with heightened insecurity in some parts of Kenya itself. The country size is approximately 571,470 square kilometres with over 80 percent of the land arid or semi-arid, and only 20 percent arable.

Kenya gained political independence from British colonial rule on December 12 1963 and became a republic in 1964. The multi-party government adopted the new Constitution of Kenya 2010 that devolves authority into 47 counties. It reaffirms the rights of all Kenyans to health services, equality and freedom from direct or indirect discrimination on any grounds. The transition to devolution remains a challenge with regard to resources, institutional capacity, information flow, monitoring and evaluation and other concerns, including for primary health care and welfare systems for which the counties have responsibility.

Kenya has 42 ethnic communities, the largest being Kikuyu, Luo, Kalenjin, Luhya, Kamba, Kisii, Mijikenda, Somali and Meru. The official languages are English and Kiswahili, with several groups also having their own language. About 80 percent of Kenyans are Christians, with Muslims and other religions being a minority.

Kenya has a diverse economy, with agriculture, manufacturing, transport, trade, real estate, finance and insurance and construction the largest contributors to gross domestic product (GDP) in 2016.¹⁸ From 2012 to 2016, GDP grew by 25 percent, with 5.8 percent growth in GDP estimated in 2016 alone, and growth in 2017 projected at 6.1 percent.¹⁹ Per capita GDP is rising but severe inequalities remain.²⁰ Kenya is also open to innovation through non-government organisations (NGOs) and social enterprises who are introducing innovations into humanitarian and development programming and aiming to improve efficiency, effectiveness and accountability. Innovations in private-public partnerships are also leveraging private resources for development.

In the last decade, however, the country has witnessed an increase in the frequency, length and severity of natural disasters and recurrent conflicts. These emerging challenges call for reinforced preparedness and response mechanisms, including greater protection for women and young girls regarding sexual and reproductive health and gender based violence (GBV).

The Economic Recovery Strategy for Wealth and Employment Creation (ERS-WEC) 2002-2008 addressed challenges for medium term poverty reduction, consolidating and harmonizing into a single framework the various aspects of development. Building on this, Kenya Vision 2030 is the country's development blue print covering the period 2008 to 2030. The Vision is based on three pillars, economic, social and political. It is being implemented in five-year Medium Term Plans (MTPs). Population dynamics, reproductive health, HIV and AIDS, youth and gender equality are comprehensively incorporated in the 1st and 2nd Medium Term Plans,

¹⁷ Data on Kenya country overview from Kenya National Bureau of Statistics.

¹⁸ Kenya National Bureau of Statistics 2017 Economic Survey Report.

¹⁹ Ibid.

²⁰ The UNDAF (p2) cites the Gini Coefficient as 0.446, ranking Kenya the 10th most unequal country globally, and the fifth most unequal in Africa

MTP I 2008-2012 and MTP II 2013-2017 respectively. MTP III is under development and will influence the 9th country programme. The draft was not yet available at the time of the evaluation.

2.1.2 Challenges and national responses for sexual and reproductive health (SRH) including HIV and AIDS

Kenya has made significant improvements in some sexual and reproductive health outcomes, for example with lower total fertility rates and reduced HIV transmission in adults. However the maternal mortality ratio (MMR) remains a challenge despite a decline from 488 in 2008/09 to 362 maternal deaths per 100,000 live births in 2014. The country failed to meet the MDG 5a target of 147/100,000.²¹ Further, counties show wide disparities in MMR, ranging from 187/100,000 in Elgeyo Marakwet to 3,795 in Mandera County. Just 15 of the 47 counties account for 98.7 percent of all maternal deaths in Kenya,²² and a mere six account for over 50 percent. High MMR is attributed to inequity, poor quality maternal health services, weak uptake of skilled care where available, weak health systems among other challenges. Only 58 percent of expectant mothers completed the recommended four antenatal care visits and 62 percent received skilled care at delivery in 2013.²³

For every maternal death, nearly 30 women suffer severe pregnancy complications including obstetric fistula (OF). The prevalence of OF in Kenya is estimated at three to four women out of every 1,000 deliveries, with many unreported cases.²⁴ Many factors contribute to the risk of OF, poor access to quality emergency obstetric services, and gender concerns especially child marriage and associated early child bearing. Women's lack of control over their sexual and reproductive health contribute to their low uptake of skilled health services. Poor implementation of existing policies, guidelines and protocols, and poor monitoring by the weak health systems exacerbate the situation.

The total fertility rate (TFR) declined from 4.9 births per woman in 2003 to 3.9 births per woman in 2014, a one child decline per woman in 11 years. The use of modern contraceptive methods has increased markedly from 32 percent in the 2003 KDHS to 53 percent in 2014.²⁵ An estimated 18 percent of currently married women have an unmet need for family planning (FP) services. Challenges affecting optimal utilization of FP include: sociocultural factors; inadequate resource allocation for FP commodities and shortage of commodities; weak forecasting and quantification especially at the sub-national level; weak supply chain management; and inadequate capacity at facility level to provide comprehensive FP services, particularly long-acting and permanent methods.²⁶ Religious and cultural challenges also arise within communities, and data capture and utilization are poor. The government has embraced the FP2020 initiative, demonstrating its commitment to address the unmet needs for family planning.

The government has also introduced new policies such as the 'Linda Mama Initiative' – a programme that aims to address critical access barriers by offering free maternity services and eliminating user fee for primary care. 'Linda Mama' is implemented through the National Hospital Insurance Fund in public, small private and faith based health facilities. The First Lady spearheads the nationwide Beyond Zero Initiative to ensure that no woman should die while

²¹ Kenya Demographic and Health Surveys 2014 and 2008/9

²² UNFPA Kenya Dispatch 13 August 2014: <http://kenya.unfpa.org/news/counties-highest-burden-maternal-mortality>

²³ Kenya Demographic and Health Survey 2014

²⁴ Maryane Waweru-Wanyama (2014): *Fistula in Kenya: The Facts and the Needed Approaches*. Flying Doctors in Africa

²⁵ Kenya Demographic and Health Surveys 2014 and 2003

²⁶ GoK/UNFPA Needs Assessment for the GoK/UNFPA 8th Country Programme (2014-2018)

giving life. This confirms Kenya's recognition of RMNCAH as a development priority and reflects its strong national commitment to bring about change.²⁷

With respect to HIV, Kenya has a generalized epidemic with multiple concurrent partnerships, high rates of discordance, low knowledge of HIV status, and low condom use contributing to new infections.²⁸ Underlying factors driving the epidemic in the general population also include mobility, GBV and socio-economic inequality. Adult HIV prevalence in 2015 stood at 6.0 percent, with 1.5 million people living with HIV, and an estimated 78,000 new infections occurring in 2015 alone.²⁹ However, prevalence differs widely around the country, with the three counties of Kisumu, Siaya, and Homa Bay, being most affected with rates of 19.3, 23.7, and 25.7 percent respectively; while Wajir (0.2 percent), Tana River (1.0 percent), and Marsabit (1.2 percent) had the lowest rates in the population aged 15 and over. Also, HIV prevalence remained highest among sex workers at 29.3 percent in 2015, and was slightly over 18 percent in men having sex with men and in people who inject drugs.³⁰ Overall HIV incidence has declined from 2013 to 2015 by 19 percent in adults aged 15 and above, but has increased in young people 15-24. Infections in children under 14 years have shown a significant decrease of almost 50 percent from 2013 to 2015, primarily thanks to an extensive elimination of mother to child HIV transmission (eMTCT) programme. However, rates of decline vary widely per county, with nine lower HIV prevalence counties showing an increase.³¹

In 2009 the government launched the National Reproductive Health and HIV and AIDS Integration Strategy³² to strengthen links between reproductive health and HIV and AIDS policies, programmes and services and improve coordination and collaboration among key agencies and organisations offering RH and HIV and AIDS services. Building on this and other developments, in June 2014, Kenya launched the Prevention Revolution Road Map to End New HIV Infections by 2030 and, also in 2014, the Kenya AIDS Strategic Framework (KASF) 2014/2015-2018/2019 supporting the Road Map. The Road Map emphasises efficient service delivery of HIV combination prevention approaches prioritising the most affected counties, with capacity strengthening and resource mobilisation particularly to address the needs and rights of women and girls. HIV testing has dramatically increased and is projected to have reached over 10 million people in 2017, and other priorities include a comprehensive condom programme that has increased condom usage, voluntary medical male circumcision, and comprehensive HIV prevention programmes to reach key populations.³³

2.1.3 Challenges and national responses for adolescents and young people

Kenya has a young population with adolescents aged 10-19 constituting about 24 per cent of the country's population.³⁴ Adolescents and young people in Kenya, as elsewhere on the continent, face significant vulnerabilities and challenges to their health and general wellbeing. These include early and unintended pregnancies, child marriage, unsafe abortion, female genital mutilation/cutting, sexual and gender-based violence, and sexually transmitted infections, including HIV. In addition, challenges remain regarding education, training and employment of male and female youth, and youth empowerment overall.

Despite the median age of sexual debut (ASD) in the country standing at 17.4 for men and 18.0 years for women, 15 percent of women and 22 percent of men aged 20-49 had first sexual

²⁷ Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH) Investment Framework 31st January 2016

²⁸ NACC (2014): Kenya AIDS Strategic Framework 2014/15-2018/19

²⁹ Kenya NACC (2016): Kenya AIDS Response Progress Report, 2016

³⁰ *ibid*

³¹ *ibid*

³² GoK MoPHS and MMS (2009): National Reproductive Health and HIV and AIDS Integration Strategy

³³ Kenya NACC (2016): Kenya AIDS Response Progress Report, 2016

³⁴ 2009 Kenya Population and Housing Census (KPHC).

intercourse by age 15.³⁵ By county however, Migori has the lowest ASD among girls at 15.5 years while Mandera has the highest ASD at 19.4 for girls. For men, Garissa, at 23.6 years and Meru, at 14.4 years are the counties with the highest and lowest ASD respectively. With early sexual debut there are increased teenage pregnancies, with associated higher maternal and child morbidity and mortality³⁶ and increased female school dropout.³⁷ Eighteen percent of females age 15-19 were pregnant or already mothers in 2013.³⁸ Access to family planning and other SRH services for adolescents and young people remains a challenge, partly due to limited sexuality education in schools and low coverage of youth friendly health services.

Regarding HIV, despite continued decline in the incidence of HIV infections in adults, in young people aged 15-24 HIV incidence rose by 17 per cent between 2013 and 2015, accounting for 51 percent of all new adult infections in 2015 compared with 29 percent in 2013.³⁹ HIV incidence and prevalence remain higher in female than male adolescents.

Kenya has put in place adequate measures to ensure an enabling policy environment for the promotion and realization of SRH and rights of adolescents and young people including response to key health concerns such as teenage pregnancy, HIV and AIDS and GBV. This includes the National School Health Policy (2009), National Adolescent Sexual and Reproductive Health Policy (2015); National Guidelines for the provision of Adolescent and Youth Friendly Services (2016); The Kenya AIDS Strategy Framework (KASF) 2014/15-2018/19; the Education Sector Policy on HIV and AIDS (2013) and the Fast-track Plan to end HIV and AIDS among Adolescents and Young People (2015). Kenya is also signatory to the 2013 ministerial commitment on comprehensive sexuality education and SRH services for adolescents and young people in eastern and southern Africa.⁴⁰ Efforts are also underway to include adolescents and young people in development processes and to expand their education and employment opportunities, although much remains to be done. More effort is also needed to ensure implementation and operationalization of the policy frameworks.

Finally, a particular area of concern, given evidence of teenage pregnancy and HIV incidence, is the limited implementation of age appropriate comprehensive sexuality education in schools at primary or secondary levels (despite the policy infrastructure in place). Deeply rooted conservative religious and cultural values oppose SRH education and services for adolescents.

2.1.4 Challenges and national responses to gender equality and women's empowerment

Kenya remains a largely patriarchal society, although the Constitution and legal frameworks have created a supportive legal and policy environment for gender equality, and Kenya is committed to international instruments such as CEDAW⁴¹ and regional frameworks. Violence against women is widespread and largely tolerated, cutting across borders, class, race, ethnicity and religion, and exacerbating female poverty. Gender based violence (GBV) includes sexual violence, rape, physical violence and sexual harassment, and evidence suggests that it is increasing.⁴² Women's empowerment is hindered by polygamy, early marriage and harmful cultural and traditional practices such as female genital mutilation/cutting (FGM/C).⁴³ Traditional practices governing inheritance, acquisition of land and benefits accruing to

³⁵ Kenya Demographic and Health Surveys 2014 and 2008/2009

³⁶ KDHS 2014

³⁷ National ASRH Policy 2015

³⁸ KDHS 2014

³⁹ Kenya NACC (2016): Kenya AIDS Response Progress Report, 2016

⁴⁰ <http://www.unesco.org/fileadmin/MULTIMEDIA/HQ/HIV-AIDS/pdf/ESACCommitmentFINAL>

⁴¹ The Convention on the Elimination of All Forms of Discrimination Against Women, 1979

⁴² Kenya Demographic and Health Survey 2014

⁴³ Ministry of Public Service, Youth and Gender Affairs, Status of Women in Kenya Report, October 2015

agricultural produce continue to favour men. Women's ability to access the justice system is limited by legal costs, traditional justice systems, illiteracy and ignorance of their rights.⁴⁴

Regarding education, primary school enrolment of boys and girls was estimated at 89.2 percent in 2016,⁴⁵ with secondary level enrolment of both sexes at 51.3 percent. Female enrolment in tertiary education is increasing for both sexes, but at a slower rate for women who remain in the minority in both technical institutions and universities. In mid-2017 provision of sanitary pads for girls was declared national policy, a factor that should reduce how many girls stay at home during menstruation.

Annual economic surveys from 2008 to 2016 indicate that women are under-represented in waged employment in all sectors, particularly in construction, professional, technical and scientific services. They also earn less than men on average as they disproportionately occupy lower level economic positions.

Women are underrepresented in decision making positions: 28.1 percent of the diplomatic corps; 25.5 of cabinet secretaries; 19.8 percent of the National Assembly and 28.6 percent of the Supreme Court are women. The Ministry of Public Service, Youth and Gender produced the Status of Women in Kenya Report (October 2015) to document women's employment, social and political status in relation to men also found similar trends: 6 percent of elected members of county assemblies, 10 percent within the armed forces and 4.9 percent of chiefs are female. Thus female participation falls well below the Constitution commitment of 30 percent. However, the National Assembly representation of women increased from 9 percent in 2008 to 20 percent in 2013. GoK attempts to pass gender equality legislation in parliament have so far failed.

Government has recognised gender equality and women's empowerment as critical for poverty alleviation and sustainable development, as enshrined in the 2010 Constitution and in Vision 2030. Vision 2030 aims to reduce gender inequality through generating opportunities for women, women's empowerment, building their capabilities and addressing vulnerabilities. It also states that gender mainstreaming should be apparent in all government policies, plans and programmes. The Medium Term Plan of Vision 2030 includes establishing integrated one-stop GBV recovery centres in all health facilities in Kenya.

Other legislation and policies affecting women include the Sexual Offences Act of 2006, the Employment Act of 2007, the Prohibition of Female Genital Mutilation Act 2011, the National Policy on the Prevention and Response to GBV 2014, the Protection against Domestic Violence Act 2015, and the HIV and AIDS Prevention and Control Act of 2016. A National Gender and Equality Commission is in place, and many initiatives are underway to increase gender equality and women's empowerment. Civil society organisations play a key role in advocacy and building awareness in communities, faith based institutions and among duty bearers, and provide free legal aid services and psychosocial support. Despite progress, much remains to be done. Progress is being made, but inevitably there is still a great deal to be done.

However, in spite of the above, GBV is still high with four in 10 women in Kenya having experienced physical or sexual violence. Also, 21 percent have undergone FGM but with high prevalence of over 90 percent in some regions such as North Eastern (KDHS 2014).

2.1.5 Challenges and national responses for population dynamics

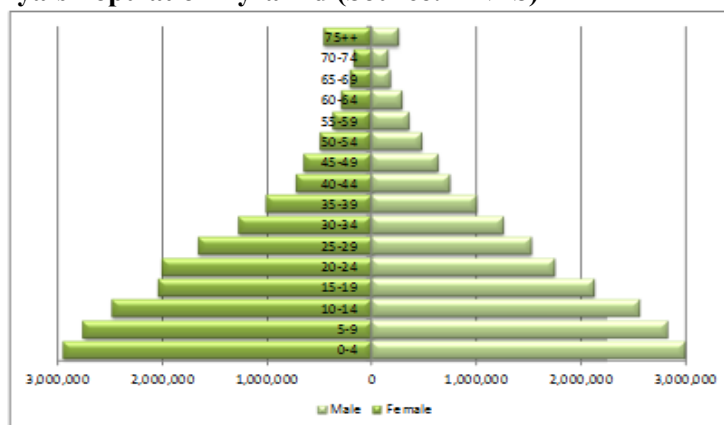
According to population projections based on 2009 census data the population is expected to reach 46,595,000 in 2017, increasing from 28.7 million in 1999, with an inter-censal

⁴⁴ Ibid

⁴⁵ Kenya National Bureau of statistics, Economic Survey 2017

population growth rate of 2.9 percent.⁴⁶ High population growth is primarily a result of declining mortality while fertility rates are declining more slowly, in addition to the net immigration arising from humanitarian crises in neighbouring countries. While total fertility has declined from a national average of seven children per woman in 1984 to four in 2014,⁴⁷ regions vary widely, with some counties registering almost double the national average.

Figure 2.1: Kenya’s Population Pyramid (Source: KNBS)



The persistent high population growth rate has resulted in a relatively large and youthful population⁴⁸ with 64 percent below 24 years of age, of whom 20.6 percent are youth aged 15 to 24 years. High population growth has resulted in rapid urbanization and growth of urban slums; high unemployment especially in youth; and issues of insecurity and substance abuse.

However, the youthful population means that Kenya can potentially benefit from the demographic dividend arising from high numbers of young people entering the workforce compared with the number of dependents. This benefit will depend heavily on the country being able to generate substantial employment opportunities for both males and females. Considerable progress has been made in extending educational opportunities, particularly through free primary education, but higher education levels are lower, particularly for females. Critically, the type of education does not prepare young people effectively for the job market.

Although Kenya periodically collects a wealth of population data, notably through the census and demographic and health surveys, in-depth analysis and dissemination and consistent collection and analysis of vital statistics are limited. For example, civil registration coverage of births and deaths is estimated at only 58 and 47 percent respectively, because of weak systems and limited human capacity.⁴⁹ In addition, data that are available on population dynamics are insufficiently used to inform policy, development planning, strategies and programme implementation at national, county and sub-county levels. Yet these data are essential to inform development across all geographical areas and all sectors.

In response to the emerging population issues, GoK formulated Sessional Paper 3 of 2012 on Population Policy for National Development, with the aim of managing population growth to a level commensurate with available resources. Government also developed the 2013 Plan of Action to provide a clear framework for the implementation of the multi-sectoral initiatives necessary to realise the policy during MTP 11 (2013-2017).

⁴⁶ Kenya Population and Housing Census, 2009.

⁴⁷ National Council for Population and Development, Policy Brief No. 53 June 2016

⁴⁸ Population Policy for National Development, 2012

⁴⁹ UNFPA Final Country Programme Document for Kenya, April 2014.

2.2 The Role of External Assistance

2.2.1 Overseas Development Assistance

The aid environment is reported as vibrant and changing (ToR, KI interviews), but facing challenges. Many traditional and emerging donors, as well as the private sector, support the Government of Kenya in realizing its Vision 2030. With Kenya reaching lower Middle Income Country (MIC) status, however, various donors are phasing out their ODA and taking on an Aid for Trade agenda. Development agencies are increasingly pressed to clearly demonstrate tangible results and show their relevance and added value.

Net ODA receipts declined from US\$ 3,308 million in 2013 to US\$ 2,474 million in 2015, and net private flows from US\$ 870 million to a net outflow of US\$ 254 million over the same period.⁵⁰ The top international donors were the USA, International Development Association (together contributing slightly over half of total ODA), the African Development Fund, the UK, European Union, Japan, Global Fund, France, Germany and Sweden in descending order of contribution. By far the largest sector for receipt of bilateral ODA was health and population at 54 percent of the total.⁵¹ Further ODA declines will require increased reliance on domestic funding for development at national and county level, involving the public and private sectors.

2.2.2 United Nations Development Assistance Framework (UNDAF)

The UNDAF 2014-2018, developed in line with the principles of the UN delivering as one (DAO), supports government ownership and is fully aligned to government priorities and planning cycles. The value base includes a human rights based approach, gender equality, environmental stability, capacity development and results based management. It has a broad-based results framework, developed jointly by UN agencies and development partners, and the strategic results areas align with the three pillars of Vision 2030 (economic, social and political). Beyond investing in coordination for the delivery of results, the UNDAF includes innovative approaches such as the cross-border initiative in Marsabit-Moyale, and a pilot county level DAO programme in Turkana.

The four strategic results areas of the UNDAF are: 1) Transformational governance that encompasses policy and institutional frameworks; 2) Human capacity development that includes education and learning, health, water and sanitation and hygiene (WASH), environmental preservation, food and nutrition, a multi-sectoral HIV and AIDS response and social protection; 3) Inclusive and sustainable economic growth including improving the business environment, strengthening productive sectors and trade; and promoting job creation, skills development and better work conditions; and 4) Environmental sustainability, land management and human security that includes the development of policy and the legal framework, and peace, security in the community and resilience. UNFPA CO was reported (UNCT and CO interviews) to be an active partner within the UN in planning and developing the UNDAF, contributing to strategic results areas 1, 2 and 4, and also leading the M&E technical working group. The mid term review of the UNDAF⁵² found it highly relevant to the development blue prints of the GoK, and overall on track to achieve its outcome targets. UNFPA also proactively supports the Kenya UNCT towards delivering as one (DAO), including for M&E, and is increasingly aligning and harmonizing operations and programmes with UN sister agencies. This is elaborated in Chapter Four.

⁵⁰https://public.tableau.com/views/OECDACaidataglacebyrecipient_new/Recipients?:embed=y&:display_count=yes&:showTabs=y&:toolbar=no?&:showVizHome=no accessed on 5 July 2017

⁵¹ Ibid

⁵² Mid Term Review of the Kenya United Nations Development Assistance Framework (UNDAF) 2014-2018

Chapter Three: UNFPA Response and Programme

3.1 UN and UNFPA Strategic Response

Chapter Two above presents a brief overview of the UN Development Assistance Framework (UNDAF) 2014 – 2018 and its alignment to country priorities, indicating the main areas of UNFPA contribution that are elaborated further in Chapter Four.

The UN system in Kenya is robust, with 25 signatories to the UNDAF and a pilot delivering as one (DAO) county, Turkana in the north-west, where there is a significant refugee population. Collaboration particularly relates to the humanitarian situation there (KI interviews and document review), including support within the camps and also the approach of linking services for the community with services for refugees. In the 8th CP the CO recruited a humanitarian specialist to strengthen CO capacity for advocacy and to leverage resources to ensure sexual and reproductive health (SRH) and gender based violence (GBV) are integrated in the humanitarian response.

The UNCT is reported to meet regularly, with UNFPA cited (UNCT and CO interviews and document review) as an active and reliable partner. UNFPA leads in the technical working groups of its mandate, and contributes actively to others, an example being leadership for monitoring and evaluation. The achievements and added value of UNFPA are reported to have scaled up considerably in the 8th CP compared with the 7th CP, particularly regarding advocacy and resource mobilization.

3.2 UNFPA Response through the Country Programme

3.2.1 The Previous Country Programme

The overall goal and strategic direction of the 7th CP (2009 – 2013) was to contribute to the first Medium Term Plan of Kenya Vision 2030, to transform Kenya into a ‘new industrializing, middle-income country providing a high quality of life to all its citizens by 2030 in a clean and secure environment’. The CP had three programme areas aligned to the outcome areas of the 2008-2013 UNFPA Strategic Plan: Reproductive Health and Rights; Population and Development; and Gender Equality. These are aligned to the International Conference on Population and Development (ICPD) Programme of Action, the Millennium Development Goals, three of the six UNDAF outcomes, and to national priorities as enshrined in the 2010 Constitution of Kenya, Vision 2030 and various laws and sectoral policies and strategies. Table 3.2 outlines the programme outputs and the outcomes they address.

Table 3.1: 7th CP Programme Areas, Outcomes and Outputs

Sexual and Reproductive Health and Rights

CP Outcome: Increased utilization of equitable, efficient and effective health services, especially for vulnerable populations; Equitable and universal access to high-quality prevention, treatment, care and support services for HIV, including the protection of human rights.

Output 1: Maternal health services, including services to prevent and manage fistula, are available, especially for young people and vulnerable groups in selected districts

Output 2: Increased gender sensitive and culturally sensitive behavior change interventions for maternal health, including family planning, fistula management, and services to prevent female genital mutilation/ cutting

Output 3: Increased availability of high-quality services to prevent HIV and sexually transmitted infections, especially for women, young people and other vulnerable groups

Gender Equality

CP Outcome: Gender equality, the empowerment of women and realization of human rights enhanced

Output 1: Increased access to accurate and appropriate information and services on sexual and gender-based violence, including in emergency and post-emergency situations

Output 2: Enhanced institutional mechanisms to reduce gender-based violence and discrimination, particularly among marginalized populations and during humanitarian crises

Output 3: Improved advocacy for the reproductive rights of women and adolescent girls, male participation in reproductive health, and the elimination of harmful practices, particularly FGM/C

Population and Development

CP Outcome: Population dynamics issues and their interlinkages with gender equality, sexual and reproductive health and rights, HIV/AIDS and vulnerable groups incorporated in public policies and programmes, poverty reduction plans and strategies and expenditure frameworks

Output 1: Improved coordination, monitoring implementation and evaluation of gender-responsive population and reproductive health policies and programmes

Output 2: Improved systematic collection, analysis and dissemination of quality gender-sensitive population and reproductive health data

The end of programme evaluation⁵³ indicates that the 7th CP was well aligned and undertook a wide range of activities to address the outputs and outcomes, but that there were some challenges regarding achievements against targets. While about 17 targets were achieved or likely to be surpassed, at least 10 targets were not reached and in several instances there were no data provided against indicators. Many factors could have contributed to this. Where the programme performed particularly well against targets was in the gender programme, and where it performed least well was against the first output for reproductive health (the main exception being upgrading facilities to treat obstetric fistula). Chapter Four (EQ1) elaborates on how the 8th CP responded to the main recommendations from the 7th CP.

3.2.2 The Current Country Programme

The Results and Resources Framework of the Country Programme Document (CPD) articulates the UNFPA Kenya programmatic response. Table 3.2 indicates the overarching national priority, UNDAF outcomes and UNFPA Strategic Plan outcomes and how the 8th CP outputs address these. The full RRF is annexed.

Table 3.2: UNFPA Kenya Response through the Country Programme

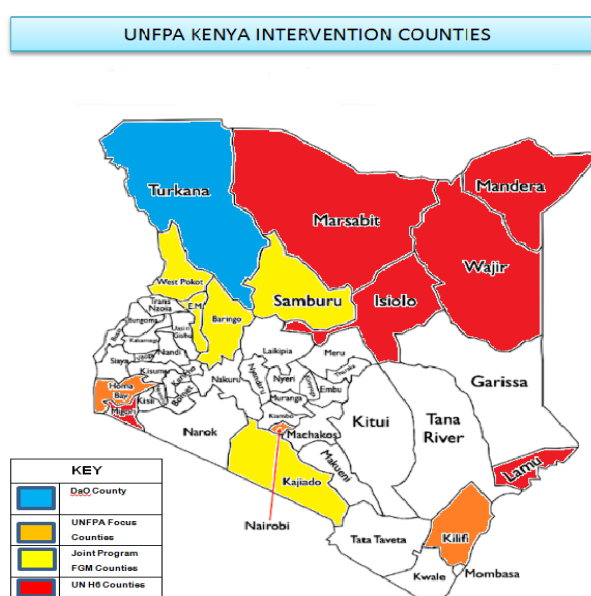
National priority: Realizing an issue-based, people-centred, results-oriented and accountable democratic system that respects the rule of law and protects the rights and freedoms of every individual in society (Vision 2030)	
UNDAF outcome 1.2: By 2017, a democracy in which human rights and gender equality are respected, elected officials are responsive and accountable; citizens and civil society are empowered, responsible and politically/socially engaged; equitable representation is achieved through affirmative action; and the electoral processes are free, fair, transparent and peaceful.	
UNDAF outcome 1.4: By 2018, development planning and decision-making are evidence and rights-based, supported by a well-established and robust research, monitoring and evaluation culture that guarantees the independence, credibility, timeliness and disaggregation of data, broadly accessible to the intended audience.	
UNDAF outcome 2.2: By 2018, morbidity and mortality in Kenya are substantially reduced, with improved maternal, neonatal, and child survival, reduced malnutrition and incidence of major endemic and epidemic diseases (malaria, tuberculosis) and stabilized population, underpinned by a universally accessible, quality and responsive health system.	
UNDAF outcome 2.3: By 2018, Kenya has reduced socioeconomic impact of HIV and societal vulnerability to HIV that is realized by a well-coordinated, effective, efficient and adequately resourced multisectoral response.	
UNDAF outcome 4.2: By 2018, counties and communities are able to anticipate, prevent and respond effectively to disasters and emergencies.	
UNFPA strategic plan outcome	Country programme outputs

⁵³ GoK/UNFPA 7th Country Programme Evaluation 2009-2013 Final Report May 2013

<p>Outcome 1: Sexual and reproductive health Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access.</p>	<p><u>Output 1:</u> National and county institutions have capacity to deliver comprehensive integrated maternal and neonatal health and HIV prevention services, including in humanitarian settings</p> <p><u>Output 2:</u> National and county institutions have capacity to create demand and provide family planning services</p>
<p>Outcome 2: Adolescents and youth Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.</p>	<p><u>Output 1:</u> Increased accessibility of comprehensive sexual and reproductive health information and services for youth at national and county levels</p>
<p>Outcome 3: Gender equality and women’s empowerment Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth.</p>	<p><u>Output 1:</u> National and county institutions have capacity to coordinate and implement compliance of obligations on gender-based violence, reproductive health rights and harmful cultural practices</p>
<p>Outcome 4: Population dynamics Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.</p>	<p><u>Output 1:</u> National and county institutions have capacity to generate and avail evidence for advocacy, planning, implementation, monitoring and evaluation of population-related policies and programmes</p>

The interventions focused on the priority counties of Homa Bay, Kilifi, Nairobi (Kasarani/Ruaraka sub-county), and also on Turkana, the DAO county. In addition, the Reproductive Maternal, Neonatal, Child and Adolescent Health (RMNCAH) project that began in 2015 is based in the six counties of Migori, Isiolo, Wajir, Marsabit, Lamu and Mandera where maternal mortality has been highest. These counties are highlighted in the following figure.

Figure 3.1: GoK/UNFPA 8th CP Intervention Counties



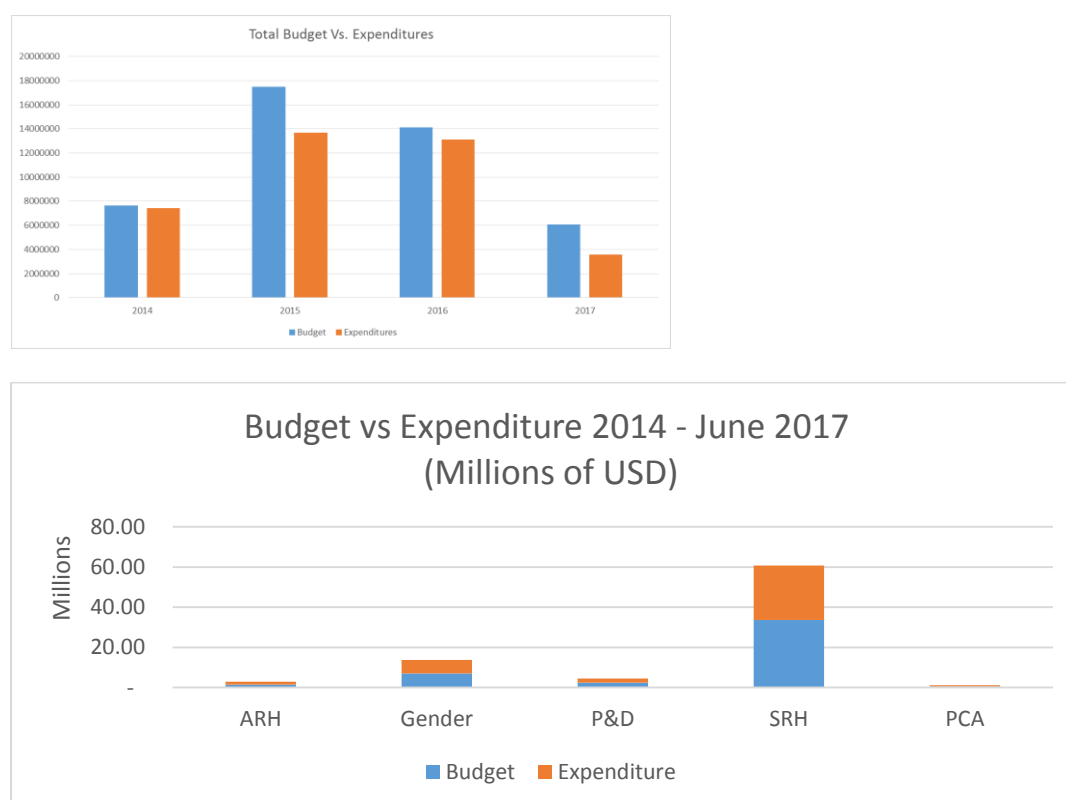
The 8th CP also took into account the recommendations and lessons learnt from the 7th Country Programme (see Chapter Four), aiming to augment the gains from the previous cycle. Overall the 8th CP builds on the 7th CP with no major shift of emphasis, but with a sharper focus on high

level advocacy for national ownership and leveraging resources, and capacity building at national and county levels (KI interviews, document review). This is appropriate for the lower middle income country status of Kenya.

3.2.3 The Country Programme Financial Structure

The CPD indicates that the UNFPA Kenya 8th CP was approved for US\$34.9 million, with US\$24.4 million from regular resources, and US\$10.5 million from co-financing modalities and/or other resources. This is a 7.4 percent increase on the US\$32.5 million approved for the previous cycle (7th CPD). Figure 3.2 summarises budget against expenditure over time, and by programme area for the 8th CP. Successful resource mobilization efforts exceeded the target of USD\$10,5 million, achieving over US\$24.2 million (231 per cent) (CO reporting).

Figure 3.2 Summary of Budget vs Expenditure for the 8th CP to Mid 2017



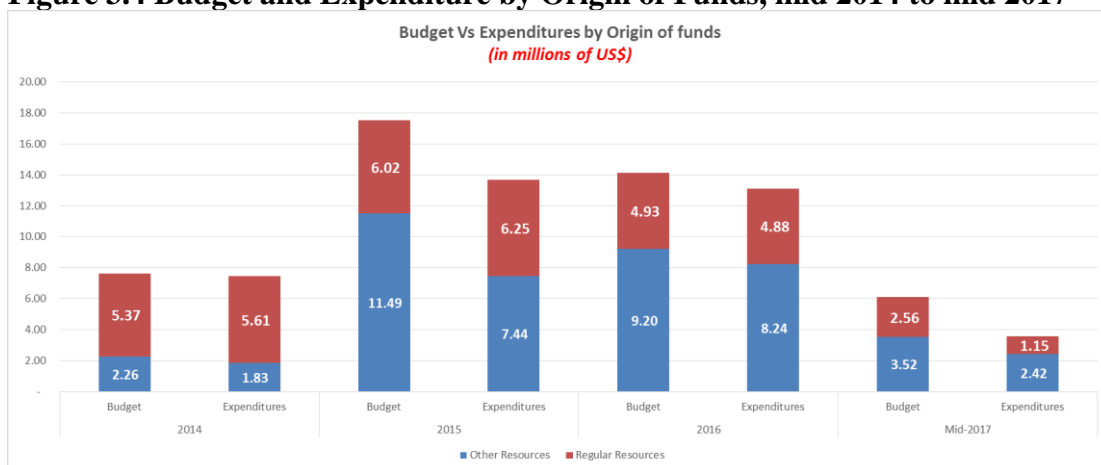
The following figure provides budget and expenditure by year by programme area. Outcome 1 (sexual and reproductive health) was originally allocated 34 percent of the budget, but successful resource mobilization, particularly from the Reproductive, Maternal, Neonatal, Child and Adolescent (RMNCAH) Trust Fund of US\$14.9 million for the first phase of the RMNCAH project, meant that in 2015 the budget had increased substantially. The expenditure on SRH of US\$10.6 million represented 78 percent of the total annual CP expenditure of US\$13.7 million for 2015, and 75 percent in 2016. The first column designated ARH refers to the adolescent and youth programme.

Figure 3.3 Budget and Expenditure by Programme Area and Year from mid 2014



The final figure shows yearly budget and expenditure by origin of funds. It reflects both the successful resource mobilisation efforts (other resources) and indicates the sharp decline in regular resources in 2017 (primarily linked with the drop in American support at global level). Most non-regular resources were leveraged from the RMNCAH Trust Fund as noted earlier, followed by DANIDA for Phase 2, then from the UN Central Emergency Response Fund (CERF) for the humanitarian response, from the Children’s Investment Fund Foundation (CIFF) for Choice4Change, and bilaterals (notably DfID and Sida). Denmark and the Netherlands also directly supported two junior programme officer posts (not reflected in the financial structure).

Figure 3.4 Budget and Expenditure by Origin of Funds, mid 2014 to mid 2017



The substantial cuts of around 50 percent in regular resources led to changes in both office structure and in support available to implementing partners (IPs). Chapter Four reviews this and implementation rates further across the programme areas.

Chapter Four: Findings

Introduction

The chapter on findings involved addressing the questions in the evaluation matrix, exploring assumptions and indicators, and following through on multiple information sources. It involved analysing and triangulating data from extensive document review with key informant semi-structured interviews and group discussions, questionnaires and observation. Interviews were held in the UNFPA country office, with UN sister agencies, government partners at national and county levels, donor agencies and international and national non-governmental organisations. Beneficiary focus group discussions also contributed information although these were not as extensive as planned because of challenges in access.

Evaluation Question 1: Strategic Alignment, Relevance and Responsiveness

- a) To what extent is the 8th Country Programme aligned with the ICPD POA, the MDGs and SDGs and the core strategy of UNFPA?
- b) How relevant is the programme to national laws, policies, needs and stakeholder priorities, and how responsive has it been to changes in national needs and priorities or major political shifts?
- c) How far did the country office respond to recommendations from the 7th Country Programme?
- d) How effectively does the country office coordinate with other UN agencies, including delivering as one, and particularly in areas of potential overlap?

Summary of Findings

Challenges: No significant challenges identified.

- a. The country programme is fully aligned with the ICPD POA, the MDGs and the core strategy of UNFPA. It was designed prior to finalization of the SDGs but is also in line with SDGs in all areas of the UNFPA mandate.
- b. The country programme is also fully aligned to national laws, policies, needs and stakeholder priorities in all the programme areas and has contributed extensively to building related national capacity. The needs of the population, particularly vulnerable groups such as women facing risk of high maternal mortality or sexual and gender based violence, were well taken into account in programme design and focus. The CP supported the national response in all programme areas from knowledge management and policy support, through to service levels, and has demonstrated responsiveness to changes in national needs and priorities. Examples include the changing humanitarian needs, and the designation of Kenya as a lower middle income country (MIC), requiring new funding modalities.
- c. Overall a clear response is evident to the main recommendations from the 7th CP in strategic positioning and efficiencies, particularly for monitoring and evaluation, and across all programme areas.
- d. Coordination with other UN agencies is generally strong, with evidence of good collaboration at UNCT level on delivering as one. UNFPA has taken the leadership role in all areas of its mandate and has collaborated effectively with key UN partners. No major concerns were found regarding potential overlap.

4.1.1 Strategic Alignment

4.1.1.1 Alignment of the 8th Country Programme to the ICPD POA, the MDGs and SDGs

The 8th CP is solidly grounded in the International Conference on Population and Development Programme of Action (ICPD POA) and relates to Millennium Development Goals 3 on gender,

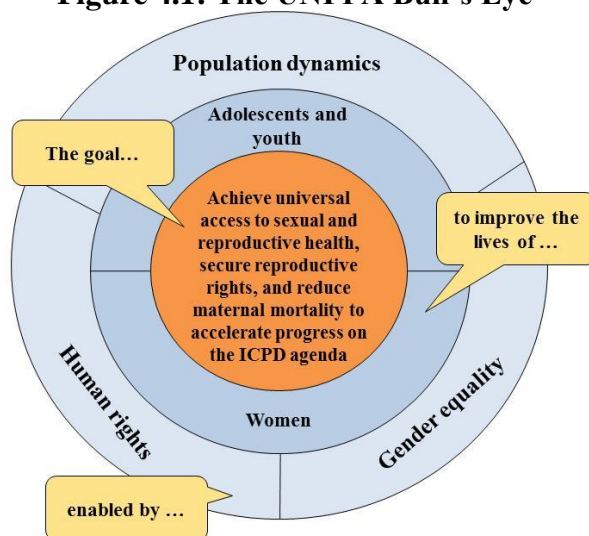
4 on reducing child mortality, 5 on improving maternal health, and 6 on combating HIV and AIDS.

The Sustainable Development Goals (SDGs), adopted in September 2015, came over a year after the start of the 8th CP. Of the 17 goals, the CP is most closely aligned with SDG 3 on health, SDG 5 on gender, SDG 10 on reduced inequalities and, because of the cross-cutting nature of some goal areas (such as education, strong institutions for justice and peace, and partnerships to address the goals) it has relevance to others also. The next CP will align more specifically to target areas within the goals.

4.1.1.2 Alignment of the 8th Country Programme to the UNFPA Strategy

The CP is fully aligned in all programme areas to the UNFPA Strategic Plan (2014-2017) that has as its ‘bull’s eye’ goal the achievement of universal access to sexual and reproductive health, the realization of reproductive rights, and the reduction of maternal mortality to accelerate progress on the ICPD agenda. With women, adolescents and youth the key beneficiaries of the work of UNFPA, achievement of the goal is enabled by addressing human rights, gender equality and population dynamics. The 8th CP incorporates the four outcome areas of the UNFPA Strategic Plan as presented in Chapter Three. These focus on: gender-responsive sexual and reproductive health (SRH) services meeting human rights standards; adolescents, especially young adolescent girls and including access to SRH services and comprehensive sexuality education (CSE); gender equality and women and girls’ empowerment, and particularly the SRH rights (SRHR) of the most vulnerable; and finally strengthening national policies and the international development agenda through effective knowledge management and integration of population dynamics in sustainable development, SRHR, HIV and gender equality. The outcomes contribute to the UNFPA bull’s eye goal in Figure 4.1.

Figure 4.1: The UNFPA Bull’s Eye



4.1.2 Relevance and Responsiveness to National Priorities

4.1.2.1 Overview

The 8th CP is strategically aligned to the 2010 Constitution and to national priorities articulated in the second Medium Term Plan (MTP 11) of the Kenya Vision 2030 Development Framework, which enshrine comprehensive human rights for all. The policy of devolution to 47 counties, each with their own local governing structures and budgets, makes it essential for UN and other development partners to engage effectively with government at both levels, as the UNFPA country office is doing extensively in its focal counties (see the map in Chapter Three). In all areas of its mandate, the UNFPA CP is aligned and/or contributed to the policies and strategies noted within each programme area below. Also, particularly in response to the designated lower

middle income country status of Kenya and declining overseas development assistance (ODA), the CO has moved towards increased high level advocacy, national and county level capacity building, and innovative resource leveraging including through private-public partnerships. KI interviews and document review indicated that the CO was highly responsive also to IP needs across all programme areas, with capacity to provide quality technical assistance in a timely manner and to respond positively to changing circumstances or expenditure requirements.

4.1.2.2 Sexual and reproductive health

The SRH outputs 1 and 2 of the 8th CP are aligned to the National Policy for Population and Development,⁵⁴ the National Reproductive Health Policy (2007), Enhancing Reproductive Health Status for All Kenyans (2007), Kenya Health Policy (2015 – 2030), and the National Reproductive Health Strategy 2009-2015. They are also relevant to the Kenya Health Sector Strategic and Investment Framework (2015 – 2018). The outputs also relate to the National Guidelines for Management of Sexual Violence (2014) and the National Family Planning Guidelines for Service Providers (2010). With respect to HIV, the CP is aligned to the 2012-2015 Strategic Framework for the Elimination of Mother to Child Transmission of HIV and Keeping Mothers Alive, the Kenya National AIDS Strategic Framework, KASF (2014/15-2018/19) that guides the national and county response, the HIV/AIDS Prevention and Control Act (2016) and the Policy for the Prevention of HIV Infections among Key Populations (2016), to the development of all of which UNFPA has contributed. The CP response was informed by evidence of priority population needs highlighted particularly in the Demographic and Health Surveys (see Chapter Two) and in the UNFPA needs assessment of 2014,⁵⁵ especially to increase contraceptive use and to reduce maternal mortality and morbidity in the highest burden counties. UNFPA mobilized resources from the RMNCH Trust Fund in support of the six-county Reproductive Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Project. It also played a critical collaborating role with the World Bank to develop the RMNCAH Investment Framework (2016).

In terms of the changing environment, UNFPA has particularly responded to the increasing humanitarian challenges of the past few years, recruiting a humanitarian specialist to lead its response and ensure that SRH and GBV needs, particularly those of women and of adolescents and youth are addressed. The CO is also adjusting to the reduced funding which has greatly affected SRH interventions and FP commodities. This is being achieved through advocacy for domestic resource mobilization and public-private partnership initiatives.

4.1.2.3 Adolescents and youth

The CP focus on adolescents and youth is aligned with the SRH policies noted above and also, in particular, with the National Adolescent Sexual and Reproductive Health Policy of 2015 (to which the CO contributed). The Constitution of Kenya (articles 53 and 55) addresses this age cohort as a key focus for the country's future development, as indicated in earlier policies such as the Kenya National Youth Policy (2003) and the Adolescent Reproductive Health and Development Policy of the same year. The 8th CP has supported further development of programme implementation frameworks and guidelines for adolescents and youth in Kenya, increased the evidence base on factors contributing to SRH-related vulnerabilities to promote policy and advocacy, and provided technical and financial support to raise knowledge and awareness, and increase youth friendliness in health services to contribute to reducing teen pregnancy, HIV infection and GBV. These needs have not substantially changed during the CP, except in that increasing numbers of adolescents and youth have been affected by humanitarian crises, that their overall numbers are increasing, and that both males and females face under-employment and many other challenges.

⁵⁴ NCPD (2012) Sessional Paper No 3 of 2012 on Population Policy for National Development

⁵⁵ GoK/UNFPA Needs Assessment for the 8th Country Programme (2014-2018)

4.1.2.4 Gender equality and women's empowerment

The focus of the 8th CP output on gender, strengthening national and county capacity around gender based violence, reproductive health rights and harmful cultural practices, is highly relevant to continuing unmet needs in the country, particularly those of the most vulnerable (document review, KI interviews, beneficiary FGD). The CP supports implementation of the Sexual Offences Act (2006), the Prohibition of Female Genital Mutilation Act (2011), the National Policy on the Prevention and Response to GBV (2014), and the Protection against Domestic Violence Act (2016). The CO has supported dissemination of gender monitoring and evaluation frameworks, and contributed to advocacy, coordination mechanisms at national and county levels, and to strategic partnerships to reduce GBV and FGM/C.

4.1.2.5 Population dynamics

The population dynamics component is aligned with Sessional Paper Number 3 on Population Policy for National Development and its Plan of Action, and also to data requirements for other policies, particularly in health. It was crucial in contributing to data generation and dissemination of information relevant for health sector planning including for SRH and for adolescents and youth, for instance regarding maternal mortality and family planning, and in relation to gender and human rights. Nonetheless, in many areas dissemination did not lead to as full and strategic use of data as desirable, and this remains a major issue of concern.

Implementing partners also confirmed the relevance of UNFPA support for their priorities as determined in the joint annual programme review and planning exercise, although their needs were reported as more extensive than UNFPA could address. Responses had to be streamlined according to available resources and key priorities. Some also suggested it might be more strategic and relevant for UNFPA to put greater resources into the population dynamics component, and to increase upstream advocacy and lobbying for full integration of population issues in all areas of development, concentrating less on selected counties.

4.1.3 Response to Recommendations from the 7th Country Programme Evaluation

4.1.3.1 Overview

The 8th CP responded effectively to the overarching recommendations that the CO: consolidate its niche in the new delivering as one focus of the UN, emphasising upstream advocacy and capacity development for impact and sustainability; expand communications and documentation and raise UNFPA visibility; and select geographical areas for programmes where needs assessment finds the greatest vulnerability for potential UNFPA beneficiaries.⁵⁶

The 7th CPE found serious challenges in the monitoring and evaluation system of the CO, and the 8th CP has revamped the M&E system and implementing partner reporting mechanisms in order to improve efficiency and relevance. The results chain logic appears stronger, although the lack of baselines for various indicators remains a challenge. The various evaluation questions elaborate on the focus and achievements of the CO and its programme areas.

4.1.3.2 Sexual and reproductive health

The 7th CPE recommended that the CO strengthen the humanitarian response, address the availability of reproductive health and family planning commodities and equipment and undertake extensive demand creation, scaling up reproductive health drop-in centres and other innovative initiatives for SRH and HIV services. The 8th CP responded to all three.

⁵⁶ See Chapter Three for the overview of the CP programme.

4.1.3.3 Adolescents and youth

The 7th CPE recommendation to consolidate support for adolescents and youth is indicated in this area being pulled out as a programme focus in its own right. Within this component, the 8th CP emphasizes the recommended technical support to government on comprehensive sexuality education and on youth friendly health services.

4.1.3.4 Gender equality and women's empowerment

Regarding gender, the 8th CP has followed the recommendation to strengthen the GBV and FGM/C focus as key human rights issues in a number of ways. The Baseline survey of GBV was not undertaken as recommended, because of resource constraints, even though a FGM/C baseline survey for the focus counties was undertaken and the overall needs assessment generated data on GBV status and management capacity in four focus counties.

4.1.3.5 Population dynamics

In response to the 7th CPE recommendations, the 8th CP strengthened IP capacity to conduct baseline studies and improve data capture, commissioned three thematic studies in areas of the UN mandate (although IP interviews found that dissemination has been insufficient), and focused on advocacy and training to improve civil registration coverage, with proven results.

4.1.4. Coordination with other UN agencies including delivering as one, and areas of potential overlap

Within the UN Country Team UNFPA was widely viewed (UNCT interviews) as an active, competent and reliable player. The contribution and status of UNFPA were rated (KI interviews with UNCT and other development partners, and document review) as substantially stronger than in the previous CP, with much higher visibility, high level advocacy, and greatly expanded resource mobilization from traditional and non-traditional sources. Linkages with government were reported as particularly strong, with UNFPA succeeding in raising government commitment to the core areas of its mandate. A key achievement was the leverage of resources for the Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) project implemented in six counties starting in 2015, and that involves all the H6 agencies, UNICEF, WHO, UNAIDS, UN Women and the World Bank in addition to UNFPA. The incoming UNFPA country representative in 2014 (now Resident Coordinator and UNDP Country Representative), together with an increasingly large and competent CO staff complement, was widely lauded (KI interviews with multiple stakeholders) as having transformed the UNFPA profile and standing. The CP was drawn up consultatively, led by the Government of Kenya, with in depth stakeholder consultations in many fora including the UNCT, but prior to the arrival of the country representative (CO feedback).

The UNCT overall was seen as strong and innovative for its cross-border regional collaboration efforts bringing together the governments of Kenya and Ethiopia, for effective resource management in UNDAF, and for convening coordinated decision making at national and county levels – areas to which UNFPA had contributed effectively.

Turkana County was selected as the pilot delivering as one (DAO) county for Kenya, and UN collaboration overall (including by UNFPA CO) addressed various aspects of joint planning, programming, financial management and monitoring and evaluation, leading the UN M&E technical working group. UNCT interviews confirmed the active involvement of UNFPA at the higher levels, although participation on the ground was reported as limited.⁵⁷ UNFPA has particularly assisted with monitoring and evaluation, providing technical assistance and finance for the development of the Turkana Monitoring and Evaluation Policy and for the implementation

⁵⁷ UNFPA was reported (CO interview) to have supported two temporary local posts and to make periodic visits to Turkana.

plan, capacity building for the Community Integration Monitoring and Evaluation System (CIMES), and supporting the launch of the County Monitoring and Evaluation Committee.

In 2016 UNFPA funded an M&E position in the office of the Resident Coordinator, but could no longer sustain this in 2017 after steep core budget reductions. Continuity has not been lost, however, as the post is now funded by another partner. Valued UNFPA contributions (KI interviews, document review) also include leadership and active participation in the technical working groups related to the UNFPA mandate, and advocacy and mobilisation of resources. During the CPE the CO was praised by the Turkana County Government for its assistance in drawing up the joint M&E policy for DAO (document noted).

With regards areas of potential overlap, no other agency has the population dynamics focus of UNFPA. At global level there is some degree of overlap regarding SRH including maternal health (e.g. with WHO), adolescents and youth (e.g. with UNICEF, UNESCO and UNAIDS) and in gender (e.g. with UN Women). However, it is anticipated that the new Secretary General will resolve this issue. Sister agencies generally reported finding the role of UNFPA valuable and supportive, however, with strong dialogue at UNCT and programme levels rather being in conflict. In one or two cases, UN partners indicated the need for greater clarity regarding roles and reported that, earlier on, there had been some friction regarding lead mandates and donor funding disbursement. However, these challenges were reported to have lessened over time as dialogue continued and agencies appreciated the UNFPA advocacy, knowledge management and resource leveraging capacity. Other development partners indicated the same.

One final concern is that some UNCT partners (KI interviews) suggested that the DAO needs to be reviewed to strengthen the focus on core joint activities and ensure the development of deeper levels of cooperation and coordination.

Evaluation Question 2: Effectiveness

- a. How adequate was the results chain logic in the component areas of the programme? To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)?**
- b. To what extent has the programme integrated the cross-cutting issues of gender and human rights based approaches?**
- c. Were there any unforeseen consequences of the UNFPA programme?**

Summary of Findings

Challenges: results chain logic, demand generation, sustainability and scalability of multiple activities with declining resources, systematic integration of gender, rights based approach.

a. The results chain logic throughout the programme was generally clear, despite a few exceptions. The interventions had a fairly high achievement rate across the programme areas, sometimes exceeding targets, with stronger achievement regarding policy and strategy development and contribution to multiple implementer projects, institutional capacity building and data generation than of demand creation. Many activities and areas of service support across SRH, AY and GEWE were noted, frequently at local levels that may not be scalable.

b. The integration of gender into the programme is apparent in that there is a specific gender-related component and to some extent a gendered approach to the SRH and adolescents and youth focus. Awareness that gender matters is clear for example in the male-involvement activity. A rights based approach is mainly apparent within the gender focus and the work with sex workers but overall is insufficiently articulated within the SRH and AY programme areas.

c. The steep reduction in regular resources (end of 2016) required unforeseen cuts in financial support. However, as far as possible these financial cutbacks were made strategically (e.g. where another partner could assist). Only in the gender component was there found a significant unforeseen consequence of the UNFPA programme, in this case concerning prosecution for FGM/C.

4.2.1 Sexual and Reproductive Health

Table 4.2.1 Summary Achievements for Sexual and Reproductive Health⁵⁸

<p>UNFPA Strategic Plan Outcome: Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV that are gender-responsive and meet human rights standards for quality of care and equity in access.</p>		
<p>Outcome indicators for Kenya CP: Percentage of births attended by skilled attendant: Baseline 43%, Target 60% National contraceptive prevalence rate: Baseline: 46%, Target 56% HIV prevalence rate among 15-24 year olds: Baseline 2.1%, Target 1.6%</p>		
<p>Country Programme Output 1: National and county institutions have capacity to deliver comprehensive integrated maternal and neonatal health and HIV prevention services</p>		
Output Indicators, Baseline and Targets for mid 2018	Key Interventions	Achievements by Q1 of 2017 against Output Indicator Targets
<ul style="list-style-type: none"> Percentage of facilities providing basic emergency obstetric and neonatal care in selected counties Baseline: Homa Bay: 7, Kilifi: 75, Kasarani/Ruaraka: 33 Target: Homa Bay: 80, Kilifi: 90, Kasarani/Ruaraka: 80; 	<ul style="list-style-type: none"> Operationalise reproductive health policies, strategies and protocols Deliver emergency obstetric care services by health facilities, and enhance skills of health service providers Implement the national HIV prevention programme, focusing on comprehensive condom programming, especially among key populations, and eliminating mother to child HIV transmission 	<p>Achievement (%): Homa Bay: 78, Kilifi: 61, Kasarani/Ruaraka: 40 % achievement against target: Homa Bay 98%, Kilifi 68%; Kasarani/Ruaraka: 50%</p>
<ul style="list-style-type: none"> Number of retired midwives recruited and trained Baseline: 124; Target: 224 		<p>Achievement: 144 Achieved 64% of target Slightly behind target</p>
<ul style="list-style-type: none"> Number of fistula cases repaired annually. Baseline (N): 750; Target (N): 1,550 	<ul style="list-style-type: none"> Equip and build county-level skills for obstetric fistula prevention and treatment 	<p>Achievement (N): 1,014 Achievement: 65% of national target</p>
<ul style="list-style-type: none"> Number of counties with disaster management plans integrating reproductive health and gender based violence Baseline: 0; Target: 4 	<p>Build capacity of staff and partners in emergency preparedness and response</p>	<p>Achievement 2 Homa Bay and Nairobi Slightly behind target</p>
<p>Country Programme Output 2: National and county institutions have capacity to create demand and provide family planning services</p>		
Output Indicators, Baseline and Targets	Key interventions	Achievements Against Output Indicators
<ul style="list-style-type: none"> Number of new users in modern contraceptive methods in select counties annually Baseline: Homa Bay: 47,334, Kilifi: 38,578; Kasarani/Ruaraka: 25,656; Target: Homa Bay: 60,000, Kilifi: 50,000, Kasarani/Ruaraka: 30,000 	<ul style="list-style-type: none"> Advocate for increased funding for procurement of FP commodities in partnership with the private sector Foster the use of voluntary family planning services through media and community outreach by addressing sociocultural barriers, including low male involvement 	<p>Achievement: Homa Bay: 81,936 (137%), Kilifi: 64,834, (130%) Kasarani/Ruaraka: 9,306 (31%) Exceeded target except in Kasarani/Ruaraka, partly due to re-arrangement of sub-counties</p>

⁵⁸ Data provided by the CO

<ul style="list-style-type: none"> Percentage of facilities providing family planning services within the HIV care clinics/centres in select counties Baseline: Homa Bay: 9 (1 out of 12), Kilifi: 35 (52/148), Kasarani/Ruaraka: 58 (14/24); Target: Homa Bay: 29, Kilifi: 55, Kasarani/Ruaraka: 78 	<ul style="list-style-type: none"> Promote the use of e-technology to ensure commodity security at the facility level and enhance supply chain management Build capacity of health workers to provide long-acting and permanent family planning methods 	Achievement (%): Homa Bay: 100, Kilifi: 47, Kasarani/Ruaraka: 80 Exceeded target in Homa Bay (345%) and Kasarani/Ruaraka. 102% against target in Kilifi (85%) on track
<ul style="list-style-type: none"> Percentage of health facilities with capacity to provide long-acting family planning methods Baseline: Homa Bay: 33, Kilifi: 58, Kasarani/Ruaraka: 54; Target: Homa Bay: 78, Kilifi: 60, Kasarani/Ruaraka:60 		Achievement (%): Homa Bay: 65, (83%), Kilifi: 47, 78%, Kasarani/Ruaraka: 63, (105%)

RMNCAH Project Performance on Key Indicators

Indicators	Isiolo			Lamu			Mandera			Marsabit			Migori			Wajir		
	B 2014	T 2016	S 2016	B 2014	T 2016	S 2016	B 2014	T 2016	S 2016	B 2014	T 2016	S 2016	B 2014	T 2016	S 2016	B 2014	T 2016	S 2016
Percent of Facilities providing BeMONC	40	48	54	69	85	96	30	35	38	34	60	92	33	55	61	36	69	74
Number of deliveries conducted by Skilled Birth Attendants	3958	4579	4521	2405	2809	2612	8380	11973	14002	4293	4615	6301	22918	30426	31026	8056	10507	11591
Number of Fistula repairs conducted	0	41	22	0	41	30	15	30	34	0	41	37	0	41	6	0	41	53

4.2.1.1 The results chain logic for the SRH component

The theory of change underlying the SRH component, as outlined in the country programme document (CPD) is generally based on sound logic. During the programme, additional baseline data were included from the RMNCAH⁵⁹ project as in the second table. Most linkages between activities to address planned interventions for the outputs and to contribute to the outcome areas are clear, and most indicators are SMART.⁶⁰ However, the HIV interventions for Output 1 had only an outcome indicator that the CP could not measure, with no guiding output indicators for the various areas of intervention.

Providing competent technical assistance, equipment and commodities, and skill development for SRH services are key interventions towards achieving the delivery of quality SRH services. Advocacy and policy support, capacity development (including infrastructure and skills development), and community engagement, are also high-impact interventions that the CO engaged in towards delivering a supportive SRH policy environment, access to quality obstetric and neonatal care, skilled birth attendance, family planning, and HIV response services. These are effective ways to contribute to outcome and impact results in reducing maternal morbidity and mortality, HIV incidence, and ensuring planned families.

4.2.1.2 The achievement of planned results

Performance against targets has in most part been highly or fully achieved, or exceeded targets as indicated above, although achievements could not be clearly quantified where the team could not access county baseline data.⁶¹ Where targets have been missed, it has mostly been because of insufficient demand. This has been partly attributed to inadequate resources to conduct community mobilization and facilitate surgical repairs (COARs, document reviews).

⁵⁹ Reproductive, Maternal, Neonatal, Child and Adolescent Health Project developed after the CPD

⁶⁰ Specific, measurable, achievable, relevant and time bound

⁶¹ Every effort was made by the SRH consultant to source baselines, including document review on the RMNCAH and repeated follow up within the CO.

The SRH interventions were implemented with national and county government counterparts and civil society implementing partners at national level and in the three focus counties of Homa Bay, Kilifi, and Nairobi (Kasarani now renamed Ruaraka sub-county). These were strategically selected on the basis of need and being inadequately resourced. High level advocacy by the CO led to the signing of a communique⁶² by 15 county governors in 2014, a key result paving the way for the Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Project. The first phase was implemented jointly by the UN H6 partners⁶³ in the six high maternal mortality burden counties of Isiolo, Lamu, Mandera, Marsabit, Migori, and Wajir, and contributed significantly to the achievement of SRH Output 1 of the CP.⁶⁴ It was also supported to the level of US\$3 million by private sector partners (document review and KI interviews). The various contributions to the key focus on emergency obstetric care (such as infrastructure, equipment and skills development) are noted in relevant paragraphs below.

Group discussion with county officers from all six counties revealed a high level of expressed commitment and ownership of the RMNCAH project. They considered the project well focused to meet community needs and indicated that they had received significant capacity development. Reported challenges were that of the three H6 partners, (WHO, UNICEF and UNFPA) only UNFPA and UNICEF appeared strongly active, and that late disbursement had delayed the start of the project. Gender and human rights, including for GBV, were insufficiently integrated, and insecurity in some counties and conservative religious attitudes impeded development in some cases. A comprehensive evaluation is needed to determine the achievements and challenges of the project, given that Kenya was not selected for an external evaluation of the RMNCH Trust Fund activities in the 19 countries where the project is implemented. The project can, however, learn from evaluation of other country projects.

The CO also provided technical and financial support for the development and revision of key SRH policies and strategies, implementation frameworks and guidelines (see EQ1).⁶⁵ These have improved the SRH policy environment and streamlined implementation across the country (document review supported by KI interviews).

The CO engaged in extensive capacity development interventions to expand access to improved quality of MNH care and services in the three focus counties of the CP and in the six high maternal mortality burden counties of the RMNCAH project. The capacity development interventions targeted skills development for health care workers (HCWs), health facility infrastructure improvements, and equipment procurement and distribution. Skills development interventions included training in EmONC, focused antenatal care, family planning especially use of long acting reversible contraceptives (LARCs) including Implanon NXT⁶⁶ and permanent methods, maternal and perinatal death surveillance and response, obstetric fistula (OF) management, and GBV.

The CO also supported midwifery capacity development in various ways. These included the recruitment and training of retired midwives, although the intervention only reached 64 percent of the targeted 224 midwives. The CO conducted a gap analysis of the midwifery programme in the country after which it supported the establishment of the Midwives Association of Kenya and an ongoing strategy to introduce a direct entry midwifery course. In collaboration with Amref Health Africa, the CO supported training for 78 midwives on leadership, management and

⁶² Signed on 28 August 2014, the communique expressed commitment to save the lives of women and girls through reducing maternal morbidity and mortality, expanding family planning, and undertaking other RMNCAH measures to ensure no woman should die giving life, and to promote safe motherhood in their high burden counties.

⁶³ UNFPA, UNICEF, WHO, UNESCO, UNAIDS and UN Women

⁶⁴ Maternal mortality assessment had found that these six counties bore over 50% of maternal mortality in Kenya.

⁶⁵ These include RMNCAH Investment Framework, guidelines on MPDSR, FP, Focused Antenatal Care, Postnatal Care, EMTCT Strategic Framework and the Kenya AIDS Strategic Framework, as well as the Kenya RH policy.

⁶⁶ Implanon NXT training was extended to 37 counties through ICRH (stakeholder feedback).

governance, and 85 midwives across six counties⁶⁷ on mentoring and coaching. It also supported development of e-learning content that was installed in health facilities in four counties (Homa Bay, Kakamega, Kilifi, and Kitui).

The CO also procured assorted lifesaving MNH equipment, ambulances to support strengthening of referral systems, infrastructure development through renovation and extension of MNH units in health facilities, and establishment of maternity waiting shelters in Kilifi, Mandera, Marsabit, and Isiolo to serve pregnant mothers from remote locations. A clearer policy on lifesaving equipment and commodities is needed, with improved tracking of stocks and advocacy for procurement of commodities. Use of the MNCH score card in the M&E framework helps track investments against outputs and contribution to outcomes and its use should continue and be strengthened to flag gaps (e.g. in family planning). It was effectively used in Migori, for example.

These capacity development interventions contributed greatly to skilled and improved quality of EmONC and wider MNH care and services in the three CP focus counties and in the six RMNCAH project counties (document review, KI interviews). However, against the CP target of expanding percentage of facilities providing Basic Emergency and Newborn Obstetric Care (BeMONC), while the CO exceeded target in the six counties of the RMNCAH project, the BeMONC target was not achieved in the three CP focus counties, with only Homa Bay (98 percent) being on track. The capacity development interventions also improved the proportion of skilled birth attendance (SBA). As a result, the proportion of SBA in the six counties, low until 2014, began to pick up and show an upward trend in 2015, a result partly attributed to the RMNCAH project meeting or exceeding the SBA targets in all the six counties.⁶⁸

In family planning (Output 2), the procurement and distribution of RH commodities, training of HCWs on FP methods and on commodity forecasting and quantification, and deployment of logistics management information systems for tracking and monitoring RH commodities have been aimed at ensuring family planning commodity security. On FP uptake, while these interventions saw numbers of new users double in the three focus counties,⁶⁹ in the six RMNCAH project counties, FP uptake declined in three counties (Isiolo, Lamu, and Marsabit), with the other three (Mandera, Migori, and Wajir) realizing marginal increase of less than 10 percent.⁷⁰ Persistent commodity stock-outs are still experienced due to a combination of factors, including inadequate capacity in forecasting and quantification, poor commodity monitoring and management and non-allocation of budgets for RH commodities by county governments. This is part of the ongoing health sector financing challenges following the devolution of health care to county governments.⁷¹

Although capacity development through infrastructure improvements, equipment supply and skills development has been considerable, this has not been accompanied by a consistent information, education and communication (IEC) strategy to enhance community engagement and demand generation. Field observation and beneficiary and IP feedback found little evidence of UNFPA-produced IEC materials, including in the drop in centres for youth and for female sex workers. Also, UNFPA-supported infrastructure and equipment was observed rarely to be UNFPA-branded so that, at least in the sites visited, IPs and beneficiaries often did not know that the CO was the provider. Nonetheless, whether or not this finding applied across all sites was not ascertained.

A further contribution to SRH by the CO was building a partnership with Unilever (CO and KI feedback). In June 2016, UNFPA and Unilever Lifebuoy in partnership with Amref Health Africa

⁶⁷ Homa Bay, Kakamega, Kilifi, Kitui, Migori and Nairobi.

⁶⁸ UNFPA Kenya (2017): RMNCAH Project Report (July 2015-December 2016)

⁶⁹ *ibid*

⁷⁰ UNFPA Kenya (2017): RMNCAH Project Report (July 2015-December 2016)

⁷¹ UNFPA Kenya: Country Office Annual Reports (2015 & 2016)

launched a novel collaboration promoting high impact interventions for maternal and newborn health and hygiene in Kenya. A model was tested first in Migori County, engaging community health workers and primary care facility staff to use behavioral change communication to promote family planning, antenatal care, skilled birth attendance, and most importantly hygiene as a means to significantly improve maternal and newborn health by preventing infections and birth complications. The results need to be documented.

The 8th CP interventions for prevention and treatment of obstetric fistula (OF) did not meet RRF targets for uptake, largely owing to challenges of identification and mobilisation of survivors. Stigma is major barrier to uptake of services for women living with OF. The fistula response, mainly through surgical camps, has been costly and, as a result, appears unsustainable.⁷² The CO has, however, supported strategic key partnerships for fistula management, including working with Amref Health Africa, Freedom from Fistula, and the Flying Doctors Society of Africa, particularly building capacity of service providers. Preventing and treating obstetric fistula remains an essential focus in Kenya and requires further exploration of a cost-effective modality to achieve this, building on lessons learned from the present programme, bringing capacity building to scale, improving multi-sectoral coordination, strengthening fistula data management, and expanding community mobilization to create demand (CO and IP interviews, document review).

The CO implemented HIV-related interventions focused on comprehensive condom programming, especially among key populations, elimination of mother to child transmission among women living with HIV, and integration of HIV in SRH services. UNFPA contributed to HIV policy articulation (see EQ1), capacity development for HIV responses among key populations, and to responses for women and young people living with HIV. For the integration of services, UNFPA supported integration of family planning and HIV services for women living with HIV, and the integrated HIV and SRH services for female sex workers (COARs 2015, 2016; KI interviews with IPs, CO programme staff).

On integration of SRH in humanitarian responses, the CO developed capacity for integration of SRH services in county emergency response plans through training of county disaster management teams. As a result, 23 county health sector budgets have Minimum Initial Service Package (MISP) budget lines, with two of the three focus counties (Homa Bay and Nairobi Ruaraka sub-county but not Kilifi) having disaster management plans integrating SRH. The programme also supported delivery of integrated SRH services during emergencies and in humanitarian settings (KI interviews with programme staff, COARs 2015, 2016, document reviews, Kenya myResults feedback). Under a reversed referral model, the programme took specialized obstetric and gynaecological care services to refugees in Kakuma and Daadab camps,⁷³ providing SRH commodities and services to the most vulnerable populations affected by emergencies. Although UNFPA was not present on the ground in refugee settings (and is not an implementer), it supported the work of partners such as Kenya Red Cross Society and the International Rescue Committee. Document review and KI interviews found the need to strengthen coordination of SRH and GBV responses in these humanitarian settings.

In keeping with the new lower middle income country status of Kenya, that requires UNFPA Kenya to focus more on capacity development, advocacy and policy dialogue, the CO actively engaged in high level SRH advocacy at both national and county levels that significantly raised the visibility of UNFPA. In 2016, UNFPA had successful advocacy engagement with the Council of Governors, County Assembly Health Committees and County Executive Committee members for Health, Senate and National Government Parliamentary Committees to advocate for increased budget allocation for SRH, and for county family planning costed implementation plans.⁷⁴ These

⁷² *ibid*

⁷³ *ibid*

⁷⁴ UNFPA Kenya: Country Office Annual Reports (2016)

high level advocacy efforts were successful in raising the national profile of UNFPA and helped pave the way for resource mobilization, but were not clearly built on an advocacy strategy applied throughout the CP. Also, these high level advocacy approaches are costly and not sustainable. The NCPD has a Communication, Advocacy and Public Education (CAPE) Strategy, however, and the CO did continue to engage closely with the NCPD, its key government counterpart and coordinator, in various fora and to undertake an extensive range of advocacy efforts at different levels. Towards the end of the 8th CP, UNFPA visibility was reported to have declined somewhat, with less engagement with key national level institutions including parliament (KI interviews with government IPs, document review), and less than optimal participation in parts of MTP 111.⁷⁵

Demand creation for SRH services was weak during the 8th CP (document review, KI interviews with county IPs). Community engagements aimed at creating demand have taken the form of occasional sensitization meetings with religious and other community leaders (COARs, RMNCAH report). The RMNCAH Project interventions on demand generation were jointly implemented with direct support from UNFPA and UNICEF and covered the broad spectrum of activities ranging from capacity building for community health volunteers, holding community dialogue and demand side financing initiatives but were insufficient to achieve the intended results. By the end of 2016 the project had not met obstetric fistula repair targets, and ANC and FP uptake remained low or had declined in the target counties.⁷⁶

Evidence generation has supported focusing SRH interventions on priority needs and vulnerable groups. The CO supported surveys and studies to generate evidence that informed selection of targets and data for intervention planning.⁷⁷

One important area of focus to reach the most vulnerable has been the CP contribution to providing clinical, psychosocial, economic and paralegal services to female sex workers (FSW). The CP supported establishment of a drop-in centre for FSWs in Kilifi to provide integrated HIV and SRH services (e.g. for FP, HIV testing and counselling and cervical cancer screening). The programme also supported development of sex workers capacity as peer educators for others. They are assigned to key hot spots where sex work is predominant and reportedly were able to enlist other sex workers in various ways including: seeking reproductive health care screening and treatment; promoting uptake of family planning (notably 100 per cent condom uptake focus); enhanced skills in negotiation for safe sex; enhanced awareness on legal rights and referral mechanisms in instances of violence or abuse as well as economic empowerment capacity and referrals. Through support to sex worker networks, a strong sense of solidarity among sex workers has emerged, evidenced by reported collective efforts to comply with regular screening, routine testing, increased condom usage, and reporting to law enforcement or women rights organisations when abuse occurs. The targeting of the programme demonstrates a clear focus on a marginalised and vulnerable constituency, with empowerment through the peer education interventions. The capacity strengthening interventions in the form of peer education also embrace components of non-discrimination and empowerment, supported by capacity development among health care workers and in health facilities to provide non-discriminatory rights-based care.

Particular challenges were noted, however, with regards the high mobility among FSW, underage girls being brought into sex work, criminalisation and stigma, and risks for physical and sexual GBV. Programmatic challenges included the limited reach and coverage. The national guidelines on peer education recommend one peer educator per maximum 80 sex workers, but the programme has enlisted and supported only 10 peer educators to reach 3000 sex workers. The numbers reached, intensity and quality of interaction plus uptake of different services by sex

⁷⁵ Also, the strategic framework acknowledges UNICEF and UNAIDS but not UNFPA

⁷⁶ UNFPA Kenya (2017): RMNCAH Project Report (July 2015-December 2016)

⁷⁷ Stigma Index Study in Kilifi and Homa Bay, National Assessment of Obstetric Fistula, National Service Delivery Point Survey, Survey on factors contributing to Maternal Mortality in Nairobi, Baseline Assessment of Total Market Approaching FP, Health Facility Assessment; Baseline Assessment – SRH/HIV/GBV/TB Integration.

workers who have been reached by the programme need to be closely monitored and evaluated to assess cost benefits and scope for scale up.

4.2.1.3 Integration of gender and a human rights based approach

One of the key interventions that the CPD outlined for demand creation was addressing male involvement as a barrier to voluntary family planning uptake. There have, however, been few interventions in the 8th CP aimed at increasing male involvement in maternal and neonatal health or family planning. In the six counties of the RMNCAH project, UNFPA supported and partnered with UN Women to implement a project aimed at increasing male involvement in Isiolo County through partnership with the HeForShe Campaign.^{78 79} The initiative has, however, had limited implementation on the ground (KI interviews with IPs, document review). The model was also not extended beyond Isiolo county, where the project expects that the county health department will support the 30 HeForShe champions that have been trained to continue advocating for male engagement campaigns.⁸⁰

The RMNCAH project is intended to include gender concerns within its programming, and evaluation is needed to highlight how effectively these, as well as other aspects of the programme, have been addressed, and the level of output and intermediary outcome results.

In HIV responses, the CP supported the National AIDS Control Council (NACC) to print and disseminate male engagement guidelines for elimination of mother to child transmission of HIV (eMTCT). The dissemination was, however, done in three non-focus counties Kisii, Kericho, and Kajiado, not UNFPA focus counties (IP reports, KI interviews with IPs and programme staff).

The 8th CP did not have a well-articulated rights based approach upon which to anchor SRH interventions (document review and KI interviews). The SRH interventions have not been premised on rights that beneficiaries (as rights holders) are entitled to, and which duty bearers (including government) should guarantee. No IPs interviewed were aware of a rights based framework to SRH interventions, although both the national laws and policies of Kenya and the expressed orientation of UNDAF and the CO enshrine the principles of rights based approaches. A rights based approach should be more clearly articulated and emphasised.

4.2.1.4 Unforeseen consequences

The evaluation did not find any significant unforeseen consequences of the SRH programme during the 8th CP (key interviews, document review), except for the cutbacks necessitated by unforeseen reduction in regular resources (discussed in EQ 3).

4.2.2 Adolescents and Youth

Table 4.2.2 Summary Achievements for Adolescents and Youth

<p>UNFPA Strategic Plan Outcome: <u>Adolescents and Youth</u> Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.</p> <p>Outcome indicators for Kenya CP: Teenage pregnancy rate: Baseline 18%, Target 15%; Percentage of young people aged 15-24 who correctly identify ways of preventing sexual transmission of HIV: Baseline 54%, Target 80%.</p>
<p>Country Programme Output 1: 1 Increased accessibility of comprehensive sexual and reproductive health information and services for youth at national and county levels</p>

⁷⁸ <http://www.heforshe.org/en>

⁷⁹ UNFPA Kenya (2017): RMNCAH Project Report (Jul. 2015-Dec. 2016)

⁸⁰ ibid

Output Indicators, Baseline and Targets	Key interventions	Achievements Against Output Indicators
<p>Number of young people accessing SRH services in selected counties annually:</p> <p>Baseline: Homa Bay N/A; Kilifi N/A, Kasarani/Ruaraka: N/A;</p> <p>Target: 60,000 in each county</p>	<ul style="list-style-type: none"> • Advocate for the integration of comprehensive sexuality education in the school curriculum • Build capacity of health service providers and provide equipment to promote youth friendly sexual and reproductive health services, especially to the most vulnerable and marginalized • Build capacity of youth networks to facilitate their meaningful participation in development processes, particularly in matters of sexual reproductive health and rights. 	<p>Achievement: Homa Bay 2,657, Kilifi 10,551, Kasarani/Ruaraka: 22,234</p> <p>Off track</p>
<p>Number of national and county institutions with capacity to provide comprehensive SRH programmes to young people</p> <p>Baseline: 0; Target: 7</p>		<p>Achievement: 9</p> <p>Exceeded target</p>
<p>Number of youth accessing voluntary HIV counselling and testing:</p> <p>Baseline: Homa Bay N/A; Kilifi N/A, Kasarani/Ruaraka N/A</p> <p>Target: 60,000 in each county</p>		<p>Achievement: Homa bay 2,605; Kilifi 23,848; Kasarani/Ruaraka 5,739</p> <p>Off track but had 58,736 hits</p>

4.2.2.1 The results chain logic for the adolescent and youth component

The results chain logic is not entirely robust, with no baseline for numbers of young people accessing SRH services or HIV counselling and testing in the focal counties. The baseline and target for institutional capacity development are clear, however. The indicators for service uptake are, in effect, outcome indicators within the overall output indicator of increasing access and information, so there is a gap in logic between the advocacy for CSE and numbers accessing SRH services, or building youth network capacity and HCT uptake (although both interventions formed part of the wider CP focus on generating demand). COARs and other reports give conflicting figures regarding the number of young people targeted and reached, making analysis of achievement towards these indicators difficult.^{81 82} Although it is appropriate not to include too many output indicators, achievements could have appeared stronger in this vibrant programme component had various other output measures been included.

Nonetheless, achieving integration of comprehensive sexuality education in the national education curriculum, making health services more youth friendly and strengthening youth networks on SRH are all focused approaches to improving adolescent and youth SRH. Multiple activities contributed to these three intervention areas and well beyond, as indicated below, such as extensive contribution to the policy environment, research, and support for projects and programmes that go significantly further than what is captured in the RRF.

4.2.2.2 The achievement of planned results

The 8th CP, as recommended in the 7th CP and the UNFPA Strategic Plan, made adolescents and youth a programme area in its own right to ensure that this cohort received specific attention to address their SRH needs. Adolescent and youth needs were also mainstreamed in other programme areas, such as within the RMNCAH, given the high rate of teen pregnancies.

Further support to reduce teen pregnancies was provided in the Choice4Change (C4C) project, a consortium of three core partners, Ipas Africa Alliance, Marie Stopes Kenya and UNFPA funded by the Children's Investment Fund Foundation, CIFF. This project is being rolled out in selected counties in Kenya, including UNFPA target counties of Homa Bay, Kilifi, Ruaraka and Turkana,

⁸¹ ibid

⁸² UNFPA Kenya (2016): Country Office Annual Report (2015)

with the aim of averting 61,000 unintended pregnancies (document review and KI interviews). The contribution of UNFPA is towards the policy environment and advocacy, which directly contribute to the effectiveness of delivery by the other partners. An evaluation was nearing completion at the time of writing, which will provide information of its achievements to date. For sustainability of results, the project aims to ensure institutionalization of ASRH information and services at national and county levels, financing of ASRH information and service programmes, and capacity building of national and county institutions to create demand for services.⁸³

Advocacy and capacity development was undertaken to scale up access to comprehensive sexuality education by youth in and out of school. UNFPA, in collaboration with UNESCO and NCPD, engaged in consultations with the Ministry of Education and Kenya Institute for Curriculum Development (KICD) on integration of age appropriate comprehensive sexuality education (AACSE) in the education curriculum. The CO also sensitized religious leaders and CSO representatives, trained curriculum developers, and supported the Ministry of Health to develop the National Guidelines on AACSE. Unfortunately, serious resistance from faith based organisations, and differences of opinion with the KICD on the age-appropriateness of information, content and terminologies meant that AACSE, in the manner advocated for by UNFPA and partners, has not been fully taken up in the ongoing curriculum review in Kenya, beyond two modules.⁸⁴ The GoK also proposes the use of sensitive terminology for CSE, Family Life Education, which is more acceptable to conservative sectors of society. It is important to identify areas of common ground between the various stakeholders in order to take this forward, and a comprehensive advocacy and stakeholder strategy should be developed to achieve this.

The CO supported interventions to build capacity for provision and integration of youth friendly services in the health system overall and in health facilities. Besides the development of the National Guidelines for Provision of Adolescent and Youth Friendly Services (2016)⁸⁵, these interventions included training of health care workers on AYFS provision, and some infrastructure development to establish youth friendly centres within health facilities or as stand-alone facilities. The evaluation found that, while the youth appreciated sensitization of health care workers on youth friendly services, they preferred stand-alone youth drop in centres (such as the Kilifi County Youth Drop In Centre) where they feel freer to interact, socialize, and also seek SRH services (KI interviews, focus group discussions and facility visits).

Involving young people in adolescent and youth SRH advocacy, capacity development and demand creation is a potentially high-impact intervention that the CO engaged in during the 8th CP. The CO developed capacity of youth networks (particularly important in relation to harnessing the youth demographic dividend), and engaged young people in ASRH advocacy, peer education, youth outreach, and in ASRH and youth friendly services training. The CO also engaged in interventions that took SRH information to where young people are through development of online and digital platforms for SRH/HIV learning and information. The innovation accelerator programme reached 62,000 young people with SRH/HIV information in 2016 alone, greatly enhancing ease of access to SRH information by the youth through interesting, youth friendly solutions.⁸⁶ Youth themselves contributed to the design, with support also from private sector partners encouraging innovation in development. It is, nonetheless, a challenge to measure the intensity or quality of these interventions and their outcome results (KI interviews, document review), an area requiring further IP focus.

The adolescent and youth programme invested heavily in evidence generation to inform policy and programme interventions, through studies, surveys, research, and assessments. Examples are the assessment of drivers of teenage pregnancy in Kasarani/Ruaraka and Kilifi (with Family

⁸³ KI interviews, document review including C4C Programme Sustainability Framework.

⁸⁴ KI interviews and document review.

⁸⁵ GoK MoH (2016). National Guidelines for Provision of Adolescent & Youth Friendly Services

⁸⁶ UNFPA Kenya (2017): Country Office Annual Report 2016

Health Options Kenya, FHOK)⁸⁷ and ICRH,⁸⁸ and a study of vulnerability of young people to SRH and HIV risks conducted in Homa Bay, Kasarani/Ruaraka, Kilifi, and Garisa counties in 2016 in collaboration with Population Council.⁸⁹ The evaluation, however, found no clear strategy or plan for targeted dissemination of the findings of the evidence generated to influence policy dialogue or inform other programmes. This would have made the research more strategic and useful. In addition, promoting behaviour change programming based on systematic barrier analysis could be a more effective approach to strengthen results.⁹⁰

Also, while SRH partners and health facilities collect extensive data that are passed on to the District Health Information System (DHIS), the CO did not request that IPs presented age disaggregated data that could support youth targeted interventions, for example teenage pregnancies within antenatal clinic data, or teenage mothers from the delivery records (facility visits in two counties and staff discussion). Given the CP emphasis on reaching particularly young adolescents these data limitations impede full analysis of results.

In order to enhance the policy environment for provision of adolescent and youth sexual and reproductive health services, the CO provided technical and financial support towards for the development and revision of policy frameworks, and implementation guidelines and tools. Key among these is the National Adolescent Sexual and Reproductive Health Policy (2015)⁹¹, and the National Guidelines for Provision of Adolescent and Youth Friendly Services (2016).⁹²

To target youth out of school the CO supported development of an SRH training module for youth in empowerment platforms including youth polytechnics, vocational training centres, the National Youth Service, and the youth being supported through economic empowerment platforms such as Uwezo Fund, Youth Enterprise Development Fund, and the Women Enterprise Development Fund. This programme has, however, not been rolled out and cannot yet be measured.

4.2.2.3 Integration of gender and a human rights based approach

A clear human rights based approach to adolescent and youth interventions was not fully articulated throughout the 8th CP (KI interviews with IPs and the CO and document review). However, awareness and demand creation, especially activities to strengthen youth networks as effective advocates for their rights, do contribute to their realisation of human rights.

Although many activities directly related to gendered issues, such as teen pregnancy, the overall focus of the adolescent and youth programme needs to elucidate gender sensitivity more explicitly and emphasise male involvement in all areas of SRH. The focus on adolescent and youth friendly services needs clearly to articulate gender friendliness also, in order to ensure that adolescent girls are not stigmatised for being sexually active or pregnant (KI interviews with IPs and IP reports and COARs). Key informants and review of IP and COAR reports did not indicate that IPs received guidance on gender mainstreaming in the adolescent and youth interventions, even though some IP activities separately targeted girls. While there were also IPs that provided sex-disaggregated data, gender mainstreaming did not appear to be the underlying objective in the disaggregation (review of IP reports, COARs).

⁸⁷ FHOK (2015): Rapid Assessment of Drivers of Teenage Pregnancies in Kasarani/Ruaraka Sub-County

⁸⁸ UNFPA Kenya and ICRH Kenya (2016): Adolescent Sexual Outcomes: Teenage Pregnancies' causes and possible solutions (Kilifi)

⁸⁹ Population Council (2016): Assessment of vulnerabilities and access to HIV and Sexual and Reproductive health services among in-school and out-of- school young people in Kenya.

⁹⁰ E.g. the AED BEHAVE framework, barrieranalysis.fh.org/what_is/behave_framework.htm

⁹¹ GoK MoH (2015). National Adolescent Sexual and Reproductive Health Policy

⁹² GoK MoH (2016). National Guidelines for Provision of Adolescent & Youth Friendly Services

4.2.2.4 Unforeseen consequences

Apart from the scale of budget cuts in regular resources, requiring streamlining of IP support and of some activities, no unforeseen consequences were identified in the adolescent and youth component of the programme.

4.2.3 Gender equality and women’s empowerment

Table 4.2.3 Summary Achievements for Gender Equality and Women Empowerment

<p>UNFPA Strategic Plan Outcome for gender equality and women’s empowerment: Advanced gender equality, women’s and girl’s empowerment and reproductive rights including for the most vulnerable and marginalized women, adolescents and youth.</p> <p>Outcome indicators for Kenya CP: Percentage of women aged 15 to 49 who have experienced physical or sexual violence: Baseline: 45%; Target: 35% Female genital mutilation/cutting prevalence rate: Baseline: 27%; Target: 26%</p>		
<p><u>Country Programme Output 1:</u> National and county institutions have capacity to coordinate and implement compliance of obligations on gender based violence, reproductive health rights and harmful cultural practices.</p>		
Output Indicators, Baseline and Targets by June 2018	Key interventions (planned in CPD)	Achievements against Output Indicator Targets by Q1 2017
<ul style="list-style-type: none"> Existence of a functional monitoring and evaluation framework to monitor compliance of obligations on gender-based violence Baseline: 0; Target: 1 	Formulate and operationalize a monitoring and evaluation framework for gender equality obligations	<p>Achievement Framework in place with other donor support and UNFPA contribution became dissemination. GBV Policy Updated FGM policy GBV Costing study^{93 94}</p>
<ul style="list-style-type: none"> Existence of standard operational procedures to provide a coordinated response to gender-based violence in the counties Baseline: 0; Target: 1 	Coordinate a gender-based violence response	<p>Achievement Procedures already developed by another partner. UNFPA undertook dissemination.</p>
<ul style="list-style-type: none"> Included in CPD narrative without an indicator and not in Results and Resources Framework 	Advocate for increased resource allocation for gender based violence prevention and response	<p>Achievement Case study produced ⁹⁵</p>
<ul style="list-style-type: none"> Percent of gender based violence survivors receiving comprehensive package of services in humanitarian settings Baseline: N/A. Target: 80 	Build capacity of health service providers, law enforcement agents and the judiciary to provide multi sectoral, gender-based violence prevention and response services, including in humanitarian situations	<p>Achievement Activities implemented but indicator was not measurable</p>
<ul style="list-style-type: none"> Number of communities that have made public declarations against female genital mutilation/cutting and early marriages in programme areas Baseline: 6; Target: 10 	Foster the abandonment of harmful cultural practices, particularly female genital mutilation/cutting and early marriage through faith-based organisations and cultural institutions	<p>Achievement 12 communities made declarations, exceeding target</p>

⁹³ Gender based violence in Kenya: The Economic burden on survivors, 2016, NGEC and JpGEWE

⁹⁴ Gender based violence in Kenya: the cost of providing services, 2016, NGEC and JpGEWE

⁹⁵ Gender responsive budgeting: Case study of Samburu, Baringo, Homa Bay, Kilifi Counties and Kasarani/Ruaraka sub- county 2015

4.2.3.1 The results chain logic for the gender equality and women's empowerment component

The results chain logic for the gender component could be strengthened in a number of respects. First, the level of outputs, targets and indicators was not always sufficiently strategic to contribute meaningfully to the outcome results (such as number of communities making public declarations). While the first two planned interventions were completed without UNFPA inputs, the dissemination of the framework and guidelines was a linked contribution. UNFPA was able to target strategically and make contributions towards: development of a GBV policy and updated FGM Policy with the State Department of Gender as well as contributing to the GBV costing study under the Joint Gender and Equality Women and Empowerment programme (Joint GEWE). Beyond the dissemination, it would have been more strategic to follow up with support for the frameworks and standard operating procedures including a review of how well they were utilized. Care is needed to ensure that all indicators are measurable and SMART, and there needs to be complete alignment between the CPD narrative and the RRF.

4.2.3.2 The achievement of planned results

The focus of the 8th CP output on gender is towards strengthening **advocacy, capacity and coordination** at national and county levels around gender based violence, reproductive health rights and harmful cultural practices such as female genital mutilation/cutting (FGM/C) and early marriage. The approach appreciates the Kenyan context that has adopted a robust normative legal and policy framework promoting human rights and fundamental freedoms, with specific prohibition of harmful cultural practices⁹⁶ and gender based violence.⁹⁷

Towards strengthening and enhancing the normative framework and supporting national efforts on coordination, UNFPA has supported the development of the National Policy on Prevention and Response to GBV Development and the updated National Policy on abandonment of FGM 2016 (which is rights based and promoting a multisectoral approach) as well as the GBV costing study that captures the economic burden on survivors. UNFPA has also supported the development of a gender knowledge product (checklist) to guide and ensure smooth coordination of anti-FGM/C working groups in Kenya.

The UNFPA contributions to FGM interventions were funded through the UNFPA/UNICEF Joint Programme. The contributions were found to be appropriate in supporting capacities towards abandonment of FGM/C as well as the implementation of the FGM Act (document review and KI interviews). The joint programme has responded to the two main challenges to abandoning FGM/C in the country: medicalization of the practice and its religious/cultural importance.⁹⁸ Recognizing the cultural sensitivities around FGM/C, the gender component has addressed the custodians of culture and drivers of cultural change, the Council of Elders, religious leaders and morans, to provide leadership in making public declarations on the abandonment of the practice. As a result, the Council of Elders, religious leaders and/or morans from five communities have made public declarations against FGM/C, whilst 5,849 girls have undergone alternative rites of passage (ARP) and publicly declared abandonment of FGM/C (COARs). The ARP interventions have resulted in the emergence of role models who facilitate younger girls to appreciate that there are alternative ways to mark the transition to adulthood without undergoing FGM/C or early marriage. The programme also identified mentors in the community to follow up girls who have undergone ARP to support and insulate them from threats of FGM/C. Legal awareness amongst law enforcement agencies has been supported by the programme through production of an abridged version of the FGM/C law and training sessions.

⁹⁶ Article 44 (3) Constitution of Kenya

⁹⁷ Article 29 (c) Constitution of Kenya

⁹⁸ UNFPA/ UNICEF, "Female Genital mutilation/Cutting: Accelerating Change: Funding Proposal", UNFPA, UNICEF, New York, 2007.

Through community awareness interventions addressing the social norms driving FGM/C, the programme has supported capacity strengthening amongst specific groups: teachers; girls in and out of school; women's groups; religious leaders; Council of Elders; chiefs; morans; circumcisers; members of county assemblies (MCAs); health care providers; and gender and youth officers (document review, CO and IP interviews). At the end of 2016, the programme had supported mentorship programmes for 1,154 boys and girls to encourage them to abandon the practice. There are also identified mentors in communities and attached to girls who have undergone ARP to follow them up to make sure they are not threatened with FGM/C. Social norms driving the practice of FGM/C remain a long term challenge requiring continued and sustained investments. Hence the community dialogues embedded within the programme implementation continue to provide a suitable and appropriate space to interrogate and inform sustained changes in practice. The emergence of increased FGM/C within refugee camps, as well as taking girls across the border for FGM/C, require intensified protection measures.

To emphasise the harmful effects of FGM/C, the programme has invested in supporting advocacy to end the medicalization of the practice. UNFPA support to the Africa Coordinating Centre for the Abandonment of Female Genital Mutilation/Cutting (ACCAF), University of Nairobi, has resulted in 59 medical officers (32 male and 27 female) and 26 midwives being trained on the management of complications arising from FGM/C and on the importance of preventing its medicalization. The gender component has also expanded its scope to support capacities at prosecutorial levels, resulting in the establishment of an Anti-FGM and Child Marriage Unit at the Office of the Director of Public Prosecutions (ODPP) to fast track prosecution of cases of FGM/C and child marriage, with 22 prosecuting counsels assigned. UNFPA has supported ODPP to sensitize prosecution officers on enhancing the quality of investigations to assure a conviction as well as processes of examination and cross examination of vulnerable witnesses (children). As of 2016, of 75 cases prosecuted, 10 were convicted, 49 were on-going and seven were acquitted, while nine were withdrawn because of lack of evidence. This approach has raised an unexpected challenge, requiring an expanded response to provide psychosocial support to deal with trauma in the complainant (child) and family during prosecution, and particularly after a conviction.

The UNFPA/UNICEF Joint Programme has invested in joint planning and design of the programme and utilized strategies to leverage many developments, such as: the Anti-FGM Board to coordinate and oversee implementation of the Prohibition of the FGM Act; traditional and religious leaders to lead public declarations on abandonment of FGM; Alternative Rites of Passage as Public Declaration against FGM by girls; use of role models (mainly young women and morans) to create awareness in communities and mentor young girls and boys; support to women's rights organisations to create awareness and mobilise support to abandon FGM; secondment of a technical officer to the FGM Board; support for an anti-FGM/C marathon in West Pokot to create awareness on FGM/C; contribution to developing curriculum content to influence change in values and beliefs; and support to the Office of Director of Public Prosecutions to create awareness on the legal repercussions to accomplices and those involved in FGM/C as well as the prosecution of offenders. Considerable progress has been made to reverse the trends in FGM/C and early marriage. However, to achieve total abandonment will require greater attention to the underlying driving factors⁹⁹ and an integrated approach across the CO SRH and adolescents and youth programmes.

The programme has supported the strengthening of GBV networks by World Vision as a way of assuring community driven interventions to respond effectively to GBV cases in Kilifi, Homa Bay and Kasarani/Ruaraka and to influence community attitudes. UNFPA has supported training for network members to build awareness and skills, and materials to guide and help coordinate their work. This includes a GBV framework to monitor compliance with obligations on GBV and

⁹⁹ The prevalence of FGM/C and early marriages is predominantly in remote counties with poor terrain and weak infrastructure in terms of roads, availability of health services, limited security personnel and low presence of non-state actors leading advocacy efforts

standard operational procedures. The programme has also supported awareness creation in communities and camps, training of health providers and children's, gender and youth officers at county level, and case follow up. Members reported that they had acquired advocacy skills and forged networks for effective referrals particularly with law enforcement and health facilities. The capacity building efforts of law enforcement officers has resulted in increased community vigilance (group interviews, KI interview and document review).

Good practice: GBV Networks

The investment to strengthen and support GBV networks is potentially a strategic approach to changing norms that drive GBV and assisting GBV survivors. The composition of multisectoral agents enables a wide range of actors to inspire and lead the drive to break the silence and influence positive responses to assist survivors of GBV in complementary ways. These networks provide a strong infrastructure to scale up advocacy.

KI interviews, group discussions, document review

The empowerment component of training has also enabled GBV network members to identify and respond to community based drivers of GBV. The Kasarani/Ruaraka network reported idleness, unemployment, alcohol and substance abuse as key factors. They have enlisted government support with National Youth Service training and National Youth Fund catalytic funds to set up garbage collection projects, and others have linked with faith organisations for guidance and counselling, with mentorship by 2016 reaching 562 girls and boys.

The GBV networks are robustly engaging in communities and have earned some respect and trust amongst them, but they expressed concerns regarding their safety from perpetrators (group discussions with network members). Also, as volunteers, they have limited funds to meet disbursements for emergency transfers/referrals of survivors. While GBV coordination efforts are visible in Homa Bay, Kilifi and Kasarani/Ruaraka, the opportunity to replicate the same approach to FGM/C in these counties is hindered by their remote and weak health and development infrastructure.

The evaluation found that the gender equality marker¹⁰⁰ had been piloted and aligned to UNFPA reporting. The gender codes for the marker were categorised as gender stand-alone activities on the one hand and gender mainstreaming on the other. The pilot was able to generate illustrative activities, thus some of the gender stand-alone activities included FGM/C activities on positive norm change, engagement of adolescent girls on empowerment, GBV/child marriage, family planning and encouraging male responsibility. Gender mainstreaming activities included training of midwives, collection of GBV data, and husbands' school and FGM/C activities related to maternal health. However, the evaluation revealed that tool has not been utilised as anticipated and its application needs to be strengthened.

4.2.3.3 Integration of gender and a human rights based approach

The whole gender equality and women's empowerment component is gender focused and, within that, has concentrated on two critical areas of human rights violations, GBV and FGM/C, espousing a rights based analysis and approach. All IPs (KI discussion and document review) integrate this approach, including the principles of inclusion, empowerment, transparency and accountability. These principles were found to be consistently infused in programme planning.

4.2.3.4 Unforeseen consequences

The programme had not taken into account the wider harm to families when perpetrators of GBV are prosecuted and convicted. Backlash has also included low conviction rates for reported cases of GBV, lack of shelters, bribery to law enforcement agents and other factors.

¹⁰⁰ The gender marker is a tool to measure funds spent on GEWE. If a project has potential to contribute to gender equality, the gender marker predicts how significant the results are likely to be.

4.2.4 Population Dynamics

The following table presents a summary of the output achievements against key CP output indicators during the 8th CP.

Table 4.2.4: Summary Achievements for Population Dynamics

UNFPA Strategic Plan Outcome 4/CP Outcome 4: Population dynamics Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality.		
CP Output 1: National and county institutions have capacity to generate and avail evidence for advocacy, planning, implementation, monitoring and evaluation of population related policies and programmes		
CP Output indicators	Key Interventions	CP Achievements
Number of analytical population related reports (a) generated; (b) disseminated Baseline: (a) 0; (b) 0 Target: (a) 15; (b) 17	The CO supported the analysis, publishing and dissemination of the national and county level population related reports	Exceeded targets Achievement: (a) 52; (b) 18
Civil registration coverage of births Baseline: Kasarani/Ruaraka – 91.3%; Homa Bay – 40.2%; Kilifi – 61.6% Targets: Kasarani/Ruaraka – 98%; Homa Bay – 90%; Kilifi – 90%	Training of civil registration agents, stakeholder forums; follow up monitoring of agents; and mobile outreaches	Good progress but unlikely to meet targets Achieved in 2016: Kasarani/Ruaraka – 94%; Homa Bay – 66.2%; Kilifi – 63.7%
Number of county statistical offices with capacity to avail updated statistical information through integrated multi-sectoral information system (IMIS) Baseline: 0; Target: 47	CO support the revival of IMIS; training of 13 national 58 county officers from 17 counties; updating of MIS with additional datasets	Not achieved target KNBS and 17 counties were targeted to develop capacity to use IMIS, but none are doing so.
Existence of KPHS 2019 census project proposal: Baseline: None Target: proposal in place and disseminated for resource mobilization	The CO provided TA and resources for capacity assessment of KNBS to conduct 2019 KPHS census; and KPHS 2019 census proposal reviewed and finalised.	Achieved target

4.2.4.1 The results chain logic for the population dynamics component

The results chain logic is simple and well-focused with baselines and measurable targets and achievements, and SMART indicators. However, in terms of achieving the outcome result it needs to go further in measuring performance as far as dissemination, capacity building and effective utilization of the data are concerned.

4.2.4.2 Achievement of results

The population dynamics component supports four key government partners, the National Council for Population and Development (NCPD), Kenya National Bureau of Statistics (KNBS), Civil Registration Department (CRD) and the Monitoring and Evaluation Department (MED), as well as county level structures. As indicated in the table above, the CO fully met the targets for two of the output indicators: number of population analytical reports produced and disseminated; and the finalisation of Kenya Population and Housing Survey (KPHS) 2019 census proposal to guide capacity enhancement and resource mobilization for the 2019 census exercise (document review and KI interviews). For the latter, the CO provided external technical expertise and resources for the capacity assessment of the KNBS to undertake the census, and the review and finalization of the census proposal. To further prepare KNBS for the census exercise the CO supported four out of eight members of a study mission to Senegal to learn about the country's experience in the new technology that will be used in the KPHS 2019 census; and advanced training in USA for one KNBS technical officer in census and survey processing software (CSPPro).

For the CRD, the CO supported the achievement of two out of four of the institution's critical milestones (document review, KI interviews). The CO played a key role in the launching and support for the implementation of the Maternal and Child Health (MCH) Strategy that is credited with the improved birth registration coverage in the three focus counties. The strategy entails a close working relationship between the CRD and health facilities to ensure that young children born at home are registered at the point of first contact with the facilities. This was achieved through training civil registration agents, stakeholder fora, and follow up monitoring visits for support supervision and mentoring. This strategy is now being implemented in other counties with the support of other development partners. However, for the UNFPA focus counties, only one (Nairobi) is likely to achieve the target, while the other two counties – Homa Bay and Kilifi are not likely to reach the target of 90 percent coverage by 2018. Targets may have been set too high but, going forward, it may be necessary to study the factors hindering the planned coverage. One factor cited during the evaluation was lack of registration materials.

On the third indicator, the target of 47 counties with capacity built to use IMIS effectively is unlikely to be achieved during the 8th CP according to document review and KI interviews. The CO supported KNBS with the revival of the IMIS, training for 13 national and 58 county officers from 17 counties, and the update of the system with additional datasets in 2015. However, the system is still not updated with key and more recent datasets of interest to users, including the KPHS 2009 census and the KDHS 2014. This may explain why the system was not in use in KNBS or any of the counties under review. So far, the resources provided for the operationalization of this system have been inadequate to achieve the desired results of improving user access to statistical data.

The CO support for the generation and dissemination of data on population dynamics, SRH, HIV and their links to sustainable development achieved important results. These include the conduct of the National Adolescent and Youth Survey (2015) which provides evidence of the potential of achieving a demographic dividend in Kenya; survey reports produced for all 47 counties, and the in-depth analysis of KDHS 2014 which produced two analytical reports in 2016. The first is on factors affecting early sexual debut in young women aged 15-24, and the second on FP use among women in marginalised counties. Both reports are relevant for RH programming for marginalized counties and for youth, particularly for adolescent and young women. Key surveys to inform planning and programming on access to health services and RH commodity security included the Service Delivery Point and Kenya Service Provision Assessment surveys, both finalized in 2016. The survey on maternal mortality conducted in 2015 provided useful insights for policy and programming for Homa Bay and Kilifi counties.

With the CO playing a key role, CRD produced the Kenya Annual Vital Statistics reports for 2013, 2014 and 2015 and is currently developing the 2016 report to avail population related data for policy formulation and programming (KI interviews and document review). Key informants recognized this as a good practice that is being adopted in other African countries.

Regular annual events supported by the CO during the period include the launch of the State of the World Population and State of Kenya Population reports; the commemoration of the World Population Day,¹⁰¹ and Monitoring and Evaluation Week. The CO also supported national attendance at regional and international fora to build institutional capacity.

Regarding monitoring and evaluation, the CO played a key role in the revision and finalization of the National M&E Policy and Cabinet Memo which is a critical step in entrenching M&E in government. UNFPA support included strengthening of M&E technical capacity at MED through an M&E specialist for one year, training 20 national officers on evaluation and a stakeholders' forum to refine and finalize the national M&E policy. The CO also supported the implementation

¹⁰¹ The 2017 focus was on family planning

of county M&E systems in four focal counties through training, development of county indicator handbooks, and the launching of County Monitoring and Evaluation Committees (COMECs). In addition, Turkana County was supported to develop an M&E Policy and Implementation Plan. However, M&E systems in the counties overall remain weak, with insufficient support and resource received from UNFPA and other development partners. Furthermore, the CO supported activities and outputs were not sufficiently timely for much application by mid-2017 (document review, IP and CO interviews). More resources should be focused on strengthening M&E at national level and in the counties to build requisite institutional capacity, coordination mechanisms and the policy and legal environment for improved results and governance.

Another development regarding health data during the 8th CP has been exceptional national progress in Kenya on the global Health Data Collaborative,¹⁰² in which partners and donors, including UNFPA, have rallied behind a road map of national priorities to monitor the SDGs.

The CO further trained 24 of its 30 IPs to access and update their project information into e-ProMIS (CO and IP interviews and document review). While this is consistent with the government's intent on e-ProMIS, the system is not currently fully utilized. It is unlikely to produce optimum benefits until all project data are up to date.

On the implementation of population related policies, the CO played a key role in the Development of the Demographic Dividend (DemDiv) Model and Roadmap for Kenya. This included support for a regional symposium attended by 13 African countries in 2015 where a knowledge sharing platform on the demographic dividend was established; and the Africa – China conference on harnessing the demographic dividend in Africa. Policy briefs on the four pillars of the DevDiv Model (health, education, economic and governance) were also developed.

However, despite extensive achievements in building evidence and the capacity to generate data through improved systems, the current efforts¹⁰³ on dissemination of data and findings and the capacity building necessary for the utilization of these in policy formulation and programming is inadequate. Therefore it is unlikely to create the desired impact, especially at county level. Population Situation Analysis (PSA) reports were widely disseminated in only four counties and the Population Policy in nine. While it contained useful findings, the dissemination of the Maternal Mortality Survey was weak and has not achieved the desired outcomes.¹⁰⁴ The County Health Management Teams (CHMT) in Kilifi and Homa Bay counties were either unaware of the findings and/or had not integrated them into their plans. A shift in focus is needed towards effective dissemination of findings and building requisite capacity to use data effectively to guide policy, planning and programming, especially in the counties.

Although the 8th CP was fully aligned to the MTPII through the UNDAF, lack of high level outcome indicators expressly in the 8th CP M&E framework corresponding to the MTPII indicators was an area that needed to be improved (IP interviews and document review).

4.2.4.3 Integration of gender and a human rights based approach

Data in the surveys and analysis reports produced within the population dynamics component were fully sex and age disaggregated and therefore provides the opportunity to draw out gender disparities in the various areas of development, beyond the specific areas of the UNFPA mandate. The focus on gender includes recording the sex ratio of participants involved in training sessions, although it is not clear whether selection of participants specifically sought a gender balance. It is, however, a government reporting requirement of the Gender Directorate to measure the level

¹⁰² HDC Progress Report 2016-2017, May 2017. The global HDC was launched in March 2016 to support investment in monitoring health-related SDGs and to contribute to sustainable national monitoring systems and accountability.

¹⁰³ Document review, CO and IP interviews and group discussions

¹⁰⁴ *ibid*

of female involvement in government training programmes. For the civil registration of births, the focus of the MCH strategy is on women and their children.

KI interviewees were unable to articulate their institution's position regarding adoption of a human rights based approach, although various surveys include human rights issues, such as SGBV, and protection of human rights for all is enshrined in the Constitution and other legal and policy frameworks. There is need to discuss the incorporation of a rights based approach from the planning stages of the 9th CP so that all stakeholders are able to articulate what this means, how it should inform planning and implementation of interventions, and how it should be measured.

4.2.4.4 Unforeseen consequences

No unforeseen consequences of the population dynamic component were identified in KI interviews or from document review.

Evaluation Question 3: Efficiency

- a) **To what extent has UNFPA made good use of its human, financial and technical resources to pursue the achievement of the outputs and outcomes defined in the country programme?**
- b) **To what extent are results effectively and efficiently measured and contributing to accountability in the programme?**

Summary of Findings

Challenges: Delays in some financial disbursements, IP capacity regarding new financial mechanisms, and M&E for output and outcome results

- a) The country office has overall made good and efficient use of its human, financial and technical resources, ensuring a positive office environment conducive to effective communication and collaboration to address its mandate, developing an appropriate and expanded typology to meet changing needs, and with updated and efficient financial tracking mechanisms in place. The CO has actively engaged in key and strategic partnerships during the CP, notably within UNDAF, with government, with the private sector and in a donor forum. With a few exceptions, implementing partners received financial and technical support in a timely manner and as planned, and administrative, procurement and implementation modalities led to efficient execution of activities and outputs to address the outcomes. Relations between IPs and the CO appear strong, flexible and efficient, although in SRH, IPs and government would like clearer confirmation of focal points. Further CO staff and IP training in the current financial mechanisms would also be useful.
- b) The monitoring and evaluation system has greatly improved in the 8th CP and has been efficient in documenting progress against planned results, in quality assurance among implementing partners, and to guide future implementation. Across the programmes further training in M&E and reporting among various IPs would strengthen their capacity to measure output and outcome results.

4.3.1 Office typology, human resources and capacity building

During the 8th CP the office structure has grown significantly and the typology changed from that at the end of the previous programme cycle. In particular, several staff were recruited with specific skills for the changing environment (e.g. for the humanitarian response, for specific projects and to strengthen external relations and partnerships), complementing the core programmatic staff skills and experience in SRH, adolescents and youth, gender and data for development, and the cross-cutting functions of operations, management and monitoring and evaluation (M&E). Although the CO reports that each programme officer has a clear area of focus, in KI interviews

with IPs and government some confusion was expressed, particularly within SRH and adolescents and youth (which overlap in any case).¹⁰⁵

The substantial funding cuts at the end of 2016,¹⁰⁶ however, will require office restructuring over time to ensure a streamlined and multi-skilled staff complement to address the upstream needs for a lower middle income country. This means that advocacy and lobbying for political and financial commitment, knowledge management, technical assistance, oversight and quality assurance increasingly need to replace service provision as the core work of UNFPA, and the balance of skills in the office must be fully aligned to these shifting needs. The previous country representative had a particularly strong reputation in this regard (KI interviews from all sectors, finance and document review) and was able to leverage funding considerably beyond expectation at the start of the CP. A staff member was also recruited during the 8th CP specifically to raise office capacity to manage external relations and promote resource mobilization in private-public partnerships.

The departure of the country representative to become Resident Coordinator (RC) left a gap in the CO for a year of the 8th CP, placing an extremely heavy work load on the officer in charge (OIC). This was reportedly mediated by strong support from the assistant representative and by some continued guidance and advocacy by the RC who maintains strong support for the UNFPA mandate. A large number of staff report directly to the OIC, adding to her already heavy work load, but tasks are routinely shared with the assistant representative, and the new country representative arrived in July 2017.

Office systems rated quite to very efficient (interviews, observation, questionnaires and document review),¹⁰⁷ with fairly regular weekly all-office meetings that keep everyone informed about upcoming issues and facilitate reporting on matters of concern. During the 8th CP the office systems have been greatly strengthened and streamlined, especially in M&E, accounting and reporting systems (document and on line review, and CO and IP interviews). These save considerable staff time and improve accountability. Time management appears good, with staff reporting that in general they can complete their day-to-day and longer-term planned activities without excessive unanticipated interruptions or unrealistic timelines and work load (an improvement in 2017 over 2016). Time spent in meetings has been reduced and streamlined. Most staff reported that their skills are being effectively utilized. However, feedback indicated that some delegation to assistants and associates might be strengthened. Only two staff reported that their skill base was insufficiently utilized.

All CO interviews and questionnaire found a positive office culture, with staff feeling valued and having high appreciation of each other. Overall they indicated having supportive and sufficient supervision, and strong within- and between-team communication and collaboration enhanced by the open plan office system. This has contributed to strong motivation and commitment to achieving results and reduces any tendency to work in silos. An exceptionally good policy for staff health and well-being is in place, and this was reported also to enhance efficiency and effectiveness.¹⁰⁸ The one significant issue of concern reported by staff related, understandably, to the financial cuts and potential loss of jobs and of implementation capacity. However, staff appreciated the open senior management communications on this.

¹⁰⁵ This finding, from a number of IPs and government, was also experienced by the evaluators in seeking data in the office.

¹⁰⁶ USA defunding of UNFPA globally and approximately 50% cut in core resources for the Kenya CO

¹⁰⁷ A formal in-house climate assessment tool was not utilized but programme staff were reached with individual interviews and/or a brief questionnaire, and a strengths, weaknesses, opportunities and threats (SWOT) analysis was undertaken with administrative staff.

¹⁰⁸ For example, work life balance was seen to be and was reported to be good, staff have raisable desks to facilitate work standing or sitting, some have steppers, taking exercise breaks is encouraged, and flexi-time and working from home can be approved.

Office efficiency might be improved further (staff interviews and questionnaire) by, first, introducing a comprehensive induction package and process, particularly for incoming programme staff, (several of whom reported poor induction that impeded their efficiency after recruitment). Induction for administrative staff tended to be rated favourably. Second, increased opportunities and budget for staff capacity building would be valued; however, financial constraints impede this.¹⁰⁹ Many staff at different levels have done on-line training in their own time, in addition to mandatory UN training. Ensuring capacity for high level advocacy, innovative resource mobilization and brokering partnerships will be important in the next CP, and restructuring and streamlining will inevitably be required. Staff capable of addressing several key functions will be at an advantage (CO interviews).

4.3.2 Partnership coordination and technical assistance

The selection of partners across all the programme areas was found to be strategic and appropriate, including the UNDAF partners, and key partners from government at national and county level, donors and national and international non-government organisations. For example the UK Department for International Development (DfID) and UNFPA co-chair FP2020 for Kenya, collaborating closely and working with partners including faith organisations. The question arose, however (KI interviews with UN counterparts and with IPs in different programme areas) whether UNFPA may have too many partners and need to narrow the range to avoid spreading itself too thin, and to increase efficiency in the leaner funding environment.

Coordination modalities include an innovative public-private partnership, the Private Sector Health Partnership Kenya (PSHP Kenya) and the donor partnership forum, the Donor Partnership in Health/Kenya (DPHK),¹¹⁰ in both of which the CO has been an active player. PSHP Kenya is a private sector collective action initiative, spearheaded by UNFPA Kenya in September 2015, in support of the Global Strategy for Women's, Children's and Adolescents' health and Kenya's Beyond Zero Campaign and to complement the RMNCAH Project. Private sector commitments by mid 2017 in Kenya are approximately US\$3 million (CO feedback). Partners collaborate to build models utilizing the comparative advantage of both the public and private sector, focusing on the most vulnerable and poor populations in low-resource settings. The PSHP Kenya involves private sector companies Safaricom, Philips, MSD, Huawei and GSK. A secretariat convenes and coordinates the partnership through the Kenya Healthcare Federation with support of UNFPA and the partnership is supported by the Every Women Every Child Secretariat in New York and the World Economic Forum. It is open to all private sector companies and organizations both international and national, who want to get engaged in its mission and over 100 high level decision makers in government, the private sector and other constituents are reported as already engaged.

A particular focus is providing information technology. The partners also work with and build capacity and opportunities for local enterprise, such as the telecommunications network Safaricom. UNFPA has supported SRH-related capacity development of local health providers (see EQ 2) and the private sector has built their capacity to utilize the information technology opportunities available to them. Nonetheless KI interviews within the PSHP indicate that more capacity development is needed. Also, the upkeep of equipment and facilities needs to be assured and sufficient demand created to optimize service uptake. UNFPA has played an efficient and effective leadership and supportive coordination role (KI interviews and document review), as well as successful mobilizing resources from the RMNCAH Trust Fund for the project. This includes mobilizing resources from DANIDA for the second phase of the Kenya project.

¹⁰⁹ Also, staff on special contracts indicated they were not eligible for management training etc.

¹¹⁰ The DPHK, with about 21 members, coordinates bilateral and multilateral donors and foundations for health, aiming to reduce duplication of work and parallel systems and to identify gaps. Core members from the UN are UNFPA, WHO, UNICEF, UNAIDS and the World Bank; among bilaterals, USAID, Danida and DfID; and among foundations notably the Gates Foundation.

The DPHK is widely reported as an efficient and effective donor coordination mechanism in which UNFPA has also played a strong and efficient role (KI interviews, document review), including chairing the DPHK in 2016 and continuing to provide supportive coordination as deputy in 2017. The DPHK is reported as efficient and effective in addressing its core objectives to provide funding and technical assistance to the Ministry of Health, including strengthening national and county linkages. An important gap area identified by the DPHK is the lack of activity and resource mapping within counties (who is doing what where, and with what resources) to inform efficient and focused planning and programming.

During the 8th CP UNFPA played a strategic role in advocacy for resource mobilization for the RMNCAH and for innovations such as the Community Life Centre (CLC) in Mandera County. KI interviews found mixed opinions on the design, cost effectiveness and likely sustainability or replicability of the CLC, given its very high start-up costs (CO and stakeholder interviews). The centre is for all community members, but with a focus on youth friendliness. UNFPA has invested heavily both technically and financially in its establishment and acknowledges that this is a bold and calculated risk for a private-public innovation that will need close monitoring and evaluation to assess whether the results over time validate the expense. The centre, partly funded by the UNFPA Innovation Fund and implemented under the umbrella of PSHP Kenya, was inaugurated on 12th July 2017.

Implementing partners from all programme areas widely reported strong and effective technical assistance from the CO (KI interviews, document review), and also for leveraging of resources. Within the CO, programme officers indicated that they placed a high priority on ensuring rapid feedback to requests and to being flexible to meet changing requirements (for example regarding procurement to facilitate meetings). Relations between the CO and IPs were reported from both sides to be effective, efficient, flexible and cooperative. Several IPs from each of the different programme areas acknowledged the high technical competence of their respective programme officers. Thus the CO appears to have succeeded in establishing a competent and appropriate staff complement to address IP needs.

UNFPA brings together its national and international IPs in the fourth quarter (November) for an annual review and planning meeting to discuss general programme performance, to share lessons learned, look at expenditures, achievements and challenges, and to plan for the coming year (CO interviews, document review). By working together in relation to specific CP outputs and outcomes, IP coordination and sharing is enhanced, with a focus on the specific roles and contributions of each IP towards the bigger picture. Priorities and annual targets are set with milestones against which to measure achievements, with discussion and consensus on which IPs have the comparative advantage to address them. The annual IP workplans are drawn up consultatively and in the context of updated information on future UNFPA allocations – hence the timing of the meetings, although the annual cycle for UNFPA runs from July to June in line with the rest of the UN.

One issue that arose repeatedly (KI interviews with IPs including government) is whether UNFPA currently has too many IPs that may be challenging to coordinate, and that the CO may be focusing on too many areas, spreading itself too thin. This could be reducing its optimal efficiency and effectiveness to achieve results.

4.3.3 Financial resource management

Interviews, on-line review and documentation indicated that financial systems and management across the country programme are efficient and effective, with the Atlas and Enterprise Resource Planning systems working well, and financial resources being effectively distributed and accounted for. During the 8th CP significant gains in resource mobilization were obtained, particularly for the RMNCAH project as noted in Chapter Three.

The implementation rate across all programme areas and programme coordination assistance were high, ranging from 81 percent to over 100 percent¹¹¹ per completed year (see the annexed full implementation rates for regular and other resources). CO interviews and document review indicated that lower expenditure rates in 2014 and 2015 for sexual and reproductive health were due to delays in roll out of the RMNCAH project, for which greatly expanded external resources became available. Under-expenditures in general related to delayed disbursements and/or rescheduling of some activities. In the first quarter of 2017 delays in approval of workplans and/or other factors led to late disbursement to all programme areas and therefore to late implementation of activities, but by mid year only population dynamics had a low expenditure rate at 24 percent.¹¹² For population dynamics, where UNFPA provides funds directly to government partners for activities, the system was reported (KI interviews, document review) to be more efficient than when funding has to pass through an intermediary account (National Treasury; University of Nairobi for PSRI). Chapter Three provides further information on the financial structure of the programme including by programme area.

Implementing partner financial reporting has been compliant, with only three qualified IP NEX audits reported by the CO across the country programme, and all were readily resolved. Disbursement of quarterly funds depends on receipt by the CO of a satisfactory report for the previous quarter by 15th of the next month.

Regarding the sufficiency of funding for IPs, the 50 percent cut in core funding for UNFPA in 2017 has inevitably led to the dropping of certain areas of financial support. As far as possible, this has been undertaken strategically, for instance where another agency or funding source can replace the withdrawal of UNFPA support. IP requests exceed the CO resource capacity to deliver and they must be streamlined.

In 2016 the CO adopted the harmonized approach to cash transfers (HACT), which appears in general to have worked effectively (CO and IP interviews and electronic view). However, not all UN agencies have yet adopted this approach, adding to the complexity of some transfers. HACT activities involve micro-assessments, assurance plans, SPOT checks and follow ups, and audits.¹¹³ HACT training workshops have taken place (three for various groups of IPs in 2016 reported by the CO) and these are reported to have been partially effective. Held jointly with other UN partners (notably UNDP, UNICEF, WHO and WFP), the CO considers that the workshops are broad but lack enough depth. CO and IP interviewees agreed that further IP M&E and reporting capacity development is needed, but resource limits have impeded this.

4.3.4 Monitoring and evaluation

Monitoring and evaluation within the UNFPA CO appears robust, with a new M&E plan developed in 2015¹¹⁴ and an M&E planning matrix derived from the RRF that is updated each year. In addition, UNFPA led the design and contributes to the UNDAF M&E plan.¹¹⁵ In 2014 UNFPA introduced globally the Strategic Information System on planning, monitoring and reporting that is followed by the CO and is reported (CO discussion and online view) to be highly efficient, detailed and allowing for close tracking, and simple to follow.

¹¹¹ Implementation rates can exceed 100% because: 1) the Atlas system only stops charging when there is over expenditure at fund level but not at project or activity level; 2) there is an allowance of 10% over expenditures for regular resources. 3) Funds from other lines may be utilised for a project or activity (if available); CO operations management explanation

¹¹² This was reported by government partners to be due to late approval of work plans and hence long implementation delays.

¹¹³ CO and IP reports

¹¹⁴ Monitoring and Evaluation Plan, GoK/UNFPA 8th CP 2014-2018, December 2015.

¹¹⁵ UNFPA chaired the UNDAF technical working group to develop the Kenya UNDAF M&E Plan 2014-2018.

A team of two professional staff supporting programme, management and administrative staff. The CO has produced and published quality annual reports each year of the 8th CP (document review), with the annual report for 2016 finalised in January 2017 and being redesigned for publication at the time of the CPE. A mid-term review of the CP was not considered necessary in addition to the UNDAF MTR. Despite being delayed from the planned schedule, the final CPE was undertaken in sufficient time to contribute to planning for the 9th CP that begins in mid 2018.

The UNFPA RRF (annexed) was drawn up in consultation with wide-ranging stakeholders from civil society, the UN and donors, and with government leadership. It reflects national priorities, UNDAF and UNFPA Strategic Plan outcomes and CP outputs aligned to the DAO and UNDAF workplans, with a clear division of labour for collective implementation. The CO also has an extensive activity budget and progress matrix to measure UNFPA contributions.

The following table highlights the procedures in place for planning, monitoring and evaluation and reporting, including financial reporting, and their frequency by the CO and by implementing partners.

Table 4.3.1 Outline of Reporting and Quality Assurance Activities in the UNFPA CO

Type of Report/Activity	Frequency
Planning	
CPD and RRF	Every 4-5 years
CP Planning Matrix for M&E	Annual
Work Plan with IPs	Annual
Results Plan (integrates CP outputs and organisational effectiveness and efficiency (OEE))	Annual
UNDAF M&E Strategy	Every 4-5 years
UNDAF Strategic Results Area Joint Rolling Work Plan	Every 2 years
Monitoring	
CP Planning Matrix for M&E Tool	Developed at start and updated annually
Programme review of CP	Annual
IP work plan monitoring	Quarterly
Workplan Progress Report (IPs) narrative	Quarterly and annual
FACE form (IP) financial report	Quarterly
SPOT checks (akin to a mini audit) to replace previous financial monitoring process	Since 2016, each IP at least one SPOT check annually
NEX Audit IPs (financial)	One per programme cycle or annual if indicated by IP risk ranking
HQ management audit of CO	Infrequent (2011, 2017)
External audit of CO	None during 8 th CP
Evaluation	
UNDAF MTR and considered sufficient without CP MTC	Penultimate year of implementation
CPE to assess accountability in present CP and orient to next CP	Once every two CP cycles
Reporting	
Country Office Annual Report (COAR) to Executive Director	Annual
Workplan Progress Reports	Quarterly, annual
Donor reports: Dashboard according to donor requirements, uploaded by UNFPA	Annual for most donors, one or two 6-monthly
DAO reports to Programme Steering Committee	Annual

IP reporting is compliant with UNFPA requirements, with regular quarterly and annual reports based on the standard planning matrix and utilising the reporting template provided by UNFPA. Many IPs across the programme areas commented positively on the reporting system and none indicated that the reporting burden was excessive. The quality and timeliness of narrative

reporting by IPs varies, however (KI interviews and document review), with many tending to focus on activity achievements over outputs and measured contribution to outcomes. Data capture by many IPs needs to be strengthened (review of reports, KI interviews) and capacity development is needed in results based management. Draft reports are reviewed by CO programme officers who follow up with the IPs on inadequate aspects. Quality assurance is reported by the CO to be fully standardised across programme areas. In addition to reviewing reports, quarterly visits to IPs are scheduled by programme officers for quality assurance, and there are the further assessments and reports noted in the table above. Independent evaluations are periodically undertaken for flagship projects such as RMNCAH,¹¹⁶ the UN Joint Programme on FGM/C,¹¹⁷ and the Choice4Change project for young people (findings due in July/August 2017).

To support IP monitoring and reporting a capacity building workshop was held in 2014, but since then the only joint guidance, apart from HACT workshops, has been through these annual meetings (CO interviews). The CO recognised the need for more capacity building, partly because of staff attrition in the IPs, and the reality that incoming staff may not be fully inducted into the reporting requirements.

Evaluation Question 4: Added value and sustainability

a. What is the added value of UNFPA in Kenya in relation to other stakeholders and to the achievement of results?

b. To what extent have UNFPA-supported interventions contributed to capacity development in its implementing partners and communities?

c. How far has UNFPA successfully promoted national ownership regarding its programme areas?

Summary of Findings

Challenges: SRH demand creation, further national and county capacity development, including for effective dissemination and use of data, and achieving long-lasting changes in harmful gender norms and practices. Cuts in financial resources affect all programme areas.

- a) The added value of UNFPA was apparent across all programme areas compared with what would have been possible without its technical and financial support at different levels.
- b) National and county capacity development was the primary focus and achievement across all programme areas, as well as capacity development of selected IPs and beneficiaries. Further capacity development will be required in many areas.
- c) National ownership in all programme areas has been increased through the development of policies and increased resource mobilization, especially for SRH.

4.4.1 Sexual and Reproductive Health

The 8th CP has added value to what would have been achieved without the agency in several areas of its SRH mandate (government counterparts and IPs, document review, beneficiary focus group discussion). This includes: linking the national and international SRH agenda to assist the country to articulate national and local needs within its response to international SRH obligations; high level advocacy and lobbying to leverage funding for SRH, especially to reduce maternal mortality and strengthen family planning (FP); extensive capacity development within the Ministry of Health, particularly in its focal counties; technical assistance for SRH-related policy frameworks

¹¹⁶ A full external evaluation of RMNCAH had been anticipated in mid 2017 but has been reduced to a ‘Monkey’ online assessment. Kenya was not among the countries selected for full evaluation by a UNICEF-supported evaluation team (document review, CO feedback).

¹¹⁷ Commissioned by HQ in June 2017 and Kenya selected for case study, CO feedback.

and implementation guidelines to meet international standards; monitoring and evaluation; and increasing SRH commodity security. UNFPA also added value to the UN emergency response to the escalating humanitarian situations in the country by integrating SRH and GBV into the wider response, an area that had previously been largely neglected (UNFPA annual reports and KI interviews with the CO, UNCT and humanitarian IPs).

UNFPA leads on the UN mandate for SRH and maternal and neonatal health (MNH) but has supported the Ministry of Health to take leadership, thereby enhancing ownership and sustainability. The CO has provided high level advocacy and lobbying to leverage extensive funds particularly for the RMNCAH project. This flagship project is building considerable infrastructural and material resources and strengthening health staff capacity in the selected high maternal mortality counties, particularly to improve emergency maternal and neonatal care and family planning. Staff retention is reported to remain a challenge, however, and ongoing staff training and maintenance of infrastructure, equipment and commodities will be required to ensure sustainability of results. Further demand creation will also be needed to build further service uptake not just for emergency care but also for antenatal and postnatal care. Current external evaluation of the RMNCAH project will provide further information on achievements to date and likely sustainability of results.

The added value of the CO to commodity security, notably for family planning, included capacity building in the Ministry of Health for national and county level forecasting and quantification (KI interviews and document review), support for the family planning sustainability strategy, and for the National Costed Implementation Plan 2017-2020 (document review and KI interviews). UNFPA is the only UN agency engaged in FP commodity security and comprehensive condom programming, (although since 2013 USAID and DfID have been the largest donors for contraceptives in Kenya). From 2014 to 2015, UNFPA convened the national Technical Working Group on Condoms, but this was not sustained without a dedicated post-holder in UNFPA between 2015 and 2016 (KI interviews with IPs and the CO). In 2015 and 2016 UNFPA procured considerable FP commodities for the Ministry of Health and other civil society organisations in the country, additional to what would have been available in the absence of the CO.

Direct added value for HIV prevention, part of the UNFPA mandate within the UNAIDS global division of labour, appeared less evident (document review, KI interviews), despite the agency's comparative advantage in the UN with its mandate to link MNCAH, family planning, adolescents and youth, gender equality and women's empowerment and GBV with HIV prevention and support. Nonetheless, UNFPA was seen to have added some direct value regarding HIV particularly within its adolescents and youth programming, for elimination of mother to child HIV transmission, and in partnership with UN Women regarding male involvement.

In addition to capacity support for the Ministry of Health, the CO has also supported capacity, policy and/or strategy development in the Ministries of Education and Youth, Gender and Sports, and with county governments to promote sustainability of interventions for SRH. UNFPA also added value by working with the National Council for Population and Development (NCPD) and county governments for budgetary allocation to SRH to promote ownership and sustainability of SRH interventions, and to ensure integration of SRH issues in the county development plans. Nonetheless, various stakeholders indicated that, to optimize its added value and the sustainability of results, UNFPA needs to concentrate further on upstream advocacy and lobbying, for example to raise domestic resources for SRH in the absence of American funding from the end of 2016. Engaging in innovative private-public partnerships and supporting donor collaboration are two further important approaches in the 8th CP through which UNFPA has contributed to resource mobilization and to national and county capacity development to achieve sustainability of results. These need to be sustained and developed further in the next CP.

4.4.2 Adolescents and Youth

UNFPA works more comprehensively with adolescent sexual and reproductive health (ASRH) than any other UN agency, as recognised by both national and county government counterparts and all IPs. In the 8th CP UNFPA has added value to SRH in this cohort in various ways. The CP contributed to strengthening the policy environment for adolescents and youth, particularly for the gender and human rights of girls. It supported the overall UN response to HIV positive adolescents and youth as well as for HIV prevention in this cohort (KI interviews with the CO and IPs, and document review). The CO has also supported youth networks (such as AfriYan¹¹⁸) for peer education and the engagement of adolescents and youth in related policy and strategy development – skills and capacities to carry into adult- and parenthood.

The CO collaborated with UNESCO to expand age appropriate comprehensive sexuality education (AACSE) in the school curriculum, complementing the experience of UNESCO in education with technical input on adolescent and youth sexuality and sexual and reproductive health. Nonetheless, the local ownership and acceptance of AACSE remains limited with considerable cultural and religious opposition that will take time to change.

The support of UNFPA for integrated adolescent and youth friendly health services has added value to the overall SRH interventions and to health facility capacity to reach adolescents and youth, particularly females, more effectively (focus group discussions with county management teams and adolescent male and female beneficiaries, and document review.) These initiatives should lead to long-lasting benefits provided there is sufficient staff retention, on-going support and quality assurance of the services, and may be a more sustainable approach than independent youth centres offering SRH services. Conservative opposition to adolescents accessing contraception and other SRH services remains problematic, but the increased access to long-acting reversible contraceptives (through the Choice4Change, C4C) initiative as well as to male and some female condoms remain important developments. Findings of the mid 2017 C4C evaluation will indicate more clearly the potential for long-term benefits through this initiative.

4.4.3 Gender Equality and Women's Empowerment

The CO contributions have added value within the gender component through the predominant focus on capacity development for implementing partners, including duty bearers, and communities, achievements that would not have resulted without UNFPA contributions working jointly with other partners. The GEWE focus was informed by the needs assessment in 2014 and annual review and planning fora (document review, KI interview, beneficiary group discussion). This consultative approach has increased a sense of ownership and potential sustainability of results in IPs and communities. IPs and beneficiaries confirmed that their understanding of gender issues had increased through the materials production, and harmonized and coordinated advocacy and awareness creation.¹¹⁹ UNFPA contributed actively to these interventions working jointly with other partners, and added value through its technical expertise and finance.

In particular, the partnership with World Vision added value through engaging religious leaders on gender concerns, notably regarding female genital mutilation/cutting (FGM/C). Integrating rescue programmes for girls at risk of FGM/C within the schools and community has promoted local ownership and buy in. Local ownership, and hence potential for sustainability, was also promoted by anchoring the FGM/C programme at the Africa Coordinating Centre for the Abandonment of FGM/C, as well as development of strong referral systems within communities.

¹¹⁸ The African Youth and Adolescent Network

¹¹⁹ These materials include the World Vision Training manual on GBV response, ADR training, FGM checklist on coordination and training content by ACCAF, the abridged version of FGM law.

The gender based violence networks constitute key multidisciplinary actors at community level. The CO added value by expanding their knowledge and skills around GBV responses, including for advocacy (beneficiary discussions, KI interviews, document review). UNFPA was strategic in building capacity also among key duty bearers including law enforcement agents and the Council of Elders. The strengthened referral networks, particularly with law enforcement and health facilities, and beginnings of a community culture of intolerance and unacceptability of GBV, have potential to contribute to a long-lasting culture of intolerance of GBV. Training has also enabled GBV network members and others to identify and respond to community based drivers of GBV, thus putting in place better risk assessment for the prevention of GBV. Nonetheless there is far to go, and UNFPA needs to focus on how best to influence long-lasting cultural changes to reduce both GBV and FGM/C.

4.4.4 Population Dynamics

In population dynamics, all IPs¹²⁰ noted the critical and catalytic role of the UNFPA CO given that no other agency has the same mandate and technical capacity in this area. This has added value in a number of ways to what would have been possible without UNFPA support: in the leveraging of financial resources; the achievement of key results with long-term benefit; and in IP capacity building. For example, the CO leveraged resources from other development partners for the Kenya National Bureau of Statistics for major surveys. IPs and document review also indicated technical support and capacity building for population activities to promote sustainable results. In the 8th CP these have included, for example, strengthening the capacity of the Civil Registration Department (CRD) and county services for birth registration through the Maternal and Child Health Strategy, and assisting the production and dissemination of annual vital statistics reports (see box).

<p>Good Practice showing added value, capacity development, national ownership and sustainability of results</p> <p>Production of Annual Vital Statistics Reports The CO has supported the analysis of civil registration data and production of annual Vital Statistics Reports for Kenya every year since 2013. This is a best practice in providing useful population data that is being adopted in other African countries with the support of development partners such as the World Bank.</p> <p style="text-align: right;">IP and CO interviews</p>
--

The CO also played a significant technical and financial role in the conduct of various surveys, policy analysis and production of policy briefs that government could not have achieved without UNFPA support, and the CO contributed actively to the Civil Registration Technical Working Group to develop their strategic plan. The CO has also supported IPs to attend regional and international conferences, thus contributing to their understanding of global trends in population dynamics and building their capacity.

CO technical capacity in population dynamics was highly rated by IPs, including support to articulate their needs to other development partners. Certain IPs commented, however that, in their view, the CO role in high level advocacy and support for the health sector, commodity security issues and adolescent health, is currently diminishing. They hope to see UNFPA strengthen its strategic niche role regarding high level advocacy and reduce its role in implementation. As an area of comparative advantage of UNFPA in relation to other UN agencies, some IPs considered the relatively low budget for population dynamics activities (under one-fifth of the CPD budget) as too low.

¹²⁰ Corroborated by document review, UNCT and CO interviews

Because the CO worked within the existing institutional framework and engaged agencies based on their national mandates and competencies, ownership and hence commitment to sustainability already lay with the partners – for instance responsibility for demographic and health surveys and for the census. Support for the development of policy, action plans and legal instruments at national (National Monitoring and Evaluation Policy and Bill) and at county level (Turkana County) should promote sustainability and ownership at both levels of government, with other counties potentially strengthening their M&E in line with the national and Turkana County initiatives. Institutional capacity and coordination mechanisms for M&E at both national and county level remain insufficient, however, even with the policy and legal environments and institutional framework in place. There is therefore need for advocacy and lobbying to raise ownership and commitment to generate sufficient resources and capacity. Likewise, the management information systems (IMIS and e-Promis) in place do not seem to have sufficient national or local ownership, resources or capacity to be effectively operationalized, benefits are few, and their sustainability is therefore doubtful.¹²¹

With regards civil registration, (document review, KI interviews) the CRD does have the capacity to produce key outputs such as the annual vital statistics reports with support from the government and other development partners, but government resources, commitment and ownership appear insufficient to ensure that national targets for civil registration coverage are met and sustained.

Overall, despite the clear added value of UNFPA in the area of population dynamics, and the contribution to capacity development at national and county level, considerably more effort will be needed to sustain results achieved to date, and to ensure that national and county level governments give sufficient priority to this area. Further building of national and county commitment to the dissemination and especially the effective use of population data throughout all areas of development is required.

¹²¹ IP interviews, document review

Chapter Five: Conclusions

Introduction

The conclusions are drawn directly from the findings presented in the previous chapter, indicating the main conclusions at strategic level (such as strategic positioning, responsiveness and relevance, office capacity and efficiency, overall added value and sustainability of results), followed by more detailed programme findings.

5.1 Strategic Level

Conclusion 1: The 8th CP is strategically well aligned. The CO has responded appropriately to the changing environment and built a strong reputation during the 8th CP as a high level advocate and respected and trusted partner of wide-ranging stakeholders, although its visibility is declining. It has also shown innovation in developing new partnerships and projects.

The 8th CP was found to be highly relevant and aligned with international frameworks and to the UNFPA strategic plan, and to have contributed strongly to the UNDAF and the UN delivering as one approach. The CP was developed consultatively to ensure national ownership and relevance. The CO also responded appropriately to changing needs and circumstances such as worsening humanitarian crises and the new lower middle income country status of Kenya in 2014, requiring strategic upstream advocacy. During the first years of the CP high level advocacy and resource mobilization were achieved, but the visibility of the CO declined later in the CP and should be re-established. The CO is seen as a highly respected and valued partner in both national and county levels of government and among other stakeholders. This is a strong strategic basis for advocacy and mobilization of resources across all programmes. During the CP, the CO has developed innovative public-private partnerships and has also taken bold actions and risks in leading UN support to GoK for innovative projects such as RMNCAH in six counties, and the Community Life Centre in the insecure county of Mandera.

Origin: EQ1, 2, 3; Evaluation criteria: strategic alliance, relevance and responsiveness, effectiveness and efficiency; Recommendation: Strategic level R1

Conclusion 2: The CO has supported multiple activities and initiatives across the programme, with multiple implementing partners. However, this will be unsustainable and this is not the most strategic approach to contributing to outcomes and impacts.

The CO has been highly active in developing and supporting diverse implementing partners and government counterparts across its mandate, providing well received quality technical and/or financial assistance. The CO is seen as a strong technical partner to IPs across the programmes, including being reliable and readily available for consultations and advice. However, with declining core resources this approach is increasingly unsustainable and cutbacks have already been made. Ensuring sufficient resource mapping around the country for SRH, AY and gender is needed as part of the UNFPA annual needs assessment.

Origin: EQ 2; Evaluation criterion: effectiveness; Recommendation: Strategic level R2

Conclusion 3: The CO has contributed extensively to population data collection and to research to build the evidence across its mandate. However, effective dissemination of data and information and its use by stakeholders at national, county and community levels is insufficient.

Not only within the population dynamics component (see below) but also across all programme areas, the CO has generated extensive information to strengthen evidence informed policy, planning and programming. However, the impact of research and support for population data collection is limited by insufficient dissemination of findings and data in usable formats to meet diverse stakeholder needs at national, county and community levels.

Origin: EQ 2, 3; Evaluation criteria: effectiveness and efficiency; Recommendation: Strategic level R3

Conclusion 4: The CP has added value across all its programme areas compared with what would have been achieved in the absence of UNFPA.

The CP contributed to national, county, implementing partner and beneficiary capacity development that should have sustainable results provided there is sufficient staff retention, further training, support and upkeep of facilities and equipment. National and county ownership were increased through contributions to policies, strategies and other key documents. The CO was also successful in leveraging considerable non-core resources, particularly for the RMNCAH Project and the Community Life Centre.

Origin EQ 4: Evaluation criteria: added value, ownership and sustainability of results; Recommendation: Strategic level R4

Conclusion 5: The results chain logic in the results and resources framework of the CP is partly robust within the programme areas but some areas needing strengthening.

The results chain logic across the CP has a few challenges in relation to baselines, indicators and targets, impeding some measurement of results. In addition, particularly in the AY programme, many activities were undertaken and achieved that fall outside the overarching interventions, so the results chain under-represents the full achievements of the programme. The logical links between the SRH and AY programme areas are not clearly articulated. The RMNCAH Project had its own well-articulated results chain and indicators, in addition to the RRF, but few results were yet available.

Origin: EQ 2; Evaluation criteria: effectiveness of results based management; Recommendation: Strategic level R5

Conclusion 6: A rights based approach was not fully articulated in the 8th CP, although gender integration was stronger.

Although respect for human rights underlies the whole CP, rights based approaches do not appear to be strongly understood by IPs and programmes have not clearly articulated and measured a rights based framework to guide interventions except in GEWE. The CP strengthens duty bearers and rights holders in relation to GBV and FGM/C. The CP does, however, acknowledge the importance of a rights based approach and gender mainstreaming.

Origin: EQ 1, 2, Evaluation criteria: relevance and cross-cutting issues; Recommendation: Strategic level R6

5.2 Programme Level

5.2 1 Sexual and Reproductive Health

Conclusion 1: The RMNCAH project can provide valuable lessons for integrated SRH interventions, particularly to reduce maternal morbidity and mortality and teen pregnancy.

The RMNCAH is an innovative H6 and public-private partnership project to increase access to and improve quality of services, create demand, build institutional capacity and strengthen M&E systems. UNFPA leveraged extensive funding for the project and secured strong international and national buy in. County selection was based on evidence for where maternal mortality was highest, with reducing maternal mortality and morbidity a central pillar of the project.

Origin: EQ 1, 2, 4; Evaluation criteria: strategic alignment, relevance, effectiveness and added value; Recommendation: SRH R1

Conclusion 2: UNFPA is a valued partner in integrating SRH and GBV responses into the overall humanitarian response.

UNFPA is a valued humanitarian partner, having advocated for and provided quality technical support to integration of SRH and GBV support in emergency and humanitarian responses, and an M&E framework. Lack of presence on the ground in humanitarian settings limits the direct

contribution of UNFPA regarding implementation of SRH and GBV interventions in humanitarian settings, but the CO contributes through key implementing partners.

Origin: EQ 1, 2, 4; Evaluation criteria: relevance, effectiveness and added value; Recommendation: SRH R2

Conclusion 3: The current model for addressing obstetric fistula through treatment camps is not achieving high results and is not sustainable.

Treatment of obstetric fistula cases through treatment camps is not yielding results due to several factors. The model was found to be expensive and not cost efficient, with mobilization efforts not yielding the expected demand because of high levels of stigma in the community.

Origin: EQ 2; Evaluation criterion: effectiveness; Recommendation: SRH R3

Conclusion 4: The uptake of family planning services has doubled in the three CP focus counties and increased in the RMNCAH counties. There are, however, still persistent FP commodity stock-outs experienced across the counties.

The family planning interventions have seen the uptake of family planning services and commodities increase across the nine counties of the 8th CP. Persistent stock-outs are still experienced, however, because of non-allocation of budgets for FP commodities in county budgets, weak commodity quantification and forecasting, and weak demand creation.

Origin: EQ 2; Evaluation criterion: effectiveness; Recommendation: SRH R4

Conclusion 5: Insufficient demand creation for SRH services compromised the meeting of targets.

There was no overarching demand creation strategy to guide interventions aimed at creating demand for SRH services, leading to missed targets in the RMNCAH project regarding ANC attendance, obstetric fistula repairs, and FP uptake. Although one objective of the first phase of the project was to generate service demand, the CO played insufficient role in this and it did not translate into significant results.

Origin: EQ 2; Evaluation criterion: effectiveness; Recommendation: SRH R5

Conclusion 6: UNFPA is not adequately branding and communicating well its support to health infrastructure improvements and equipment supply in the country. UNFPA's brand is not easily associated with the work it is doing in the country.

There is little UNFPA branding and UNFPA-supported information, education and communication (IEC) in the UNFPA renovated health facilities and on the supplied equipment. UNFPA is therefore not sufficiently taking advantage of the opportunity provided by the health facility infrastructure improvements and health equipment supply to communicate its mandate and brand.

Origin: EQ 2, EQ4; Evaluation criterion: effectiveness; Recommendation: SRH R6

5.2.2 Adolescents and Youth

Conclusion 1: Comprehensive sexuality education interventions have not yet borne the intended result of CSE integration in the education curriculum because of considerable resistance and differences in understanding amongst stakeholders.

Resistance from key stakeholders in government and in faith based institutions and conservative communities has led to minimal achievement in integration of CSE in the school curriculum.

Origin: EQ 2; Evaluation criterion: effectiveness; Recommendation: AY R1

Conclusion 2: Active engagement of young people and youth networks in advocacy, programming and demand creation has potential for impact in increasing awareness and uptake of adolescent and youth SRH services.

The CO engaged young people well in advocacy, demand creation, and in raising SRH awareness of adolescents and youth through the Youth Advisory Panel, youth networks, peer educators, training and online digital platforms. These approaches help build confidence and skills among adolescents and youth and are more likely to encourage behaviour change, but they have not yet systematically addressed key barriers to behaviour change and service uptake to achieve targets.
Origin: EQ 2, 3; Evaluation criteria: effectiveness, efficiency; Recommendation: AY R2

Conclusion 3: Integration of youth friendly SRH services may be more sustainable than stand-alone youth facilities but have not been demonstrated to attract sufficient uptake. The Community Life Centre, addressing all ages and focused on youth friendliness, has high start-up costs and will need close M&E of results to assess its cost benefits and scalability.

While integration of youth friendly services in existing health facilities appears more sustainable than free-standing youth facilities, adolescents and youth may prefer free-standing facilities to services based within facilities. Demand generation has been insufficient. The services also need to assure gender friendliness.

Origin: EQ 2; Evaluation criterion: effectiveness; Recommendation: AY R3

Conclusion 4: Use of digital and online platforms has potential to increase access by adolescents and youth to SRH information.

By supporting digital innovation driven by young people, UNFPA was able to engage young people through technology and online platforms to increase their access to SRH information and services. More young people were reached with SRH information through online platforms than through conventional methods.

Origin: EQ 2; Evaluation criterion: effectiveness; Recommendation: AY R4

5.2.3 Gender Equality and Women's Empowerment

Conclusion 1: The CO has achieved its targets despite some areas of duplication.

The gender component delivered on most planned interventions, specifically around advocacy, coordination and capacity building on GBV response and management and abandonment of FGM/C. Inadequate collaboration between partners led to some duplication of planned activities.

Origin: EQ 2 Evaluation criterion: Effectiveness; Recommendation: GEWE R1

Conclusion 2: The CO has enhanced the capacities of key actors in both supply and demand.

Following the success of 7th CP in advocacy initiatives that resulted in a gender responsive legal and policy framework, UNFPA has transitioned well to further support the implementation of these laws to provide related services. Through capacity strengthening of duty bearers and non-state actors, capacity of key agencies has improved in the execution of their mandates for GBV and FGM/C. In addition, the UNPFA has contributed to community based mechanisms to generate demand, e.g. through the GBV networks.

Origin: EQ 3 Evaluation criterion: Efficiency; Recommendation: GEWE R2

Conclusion 3: There is increased discourse on socio-cultural norms, but insufficient strategies for long-term cultural change. Preparedness for backlash in communities is inadequate.

The community interventions on GBV and FGM/C have enabled a more robust conversation around related socio-cultural norms but were found inadequate to achieve long-term change and to lack sufficient risk mitigation and preparedness for backlash by conservative faith organisation and other communities.

Origin: EQ 2 Evaluation criterion: Effectiveness; Recommendation: GEWE R3

Conclusion 4: The presence of the gender marker to measure GEWE financial support against likelihood of results is a positive development that needs strengthening.

That the gender marker is available for use across UN agencies in the focus counties is commendable, and there is evidence of UNFPA piloting and aligning it within its programme activities. However, insufficient use has been made of the tool for reporting, so that its impact has been limited.

Origin: EQ 2 Evaluation criterion: Effectiveness; Recommendation: GEWE R4

5.2.4 Population Dynamics

Conclusion 1: The CO has achieved and in some cases exceeded its targets for data generation but dissemination and capacity building has been inadequate.

The CO has performed well and in some cases exceeded its targets on the generation of data for PD, SRH and youth, but dissemination and capacity building especially at county level has been inadequate to result in the desired outcomes.

Origin: EQ2; Evaluation criteria: Effectiveness; Associated Recommendation: PD R1

Conclusion 2: There is less emphasis and resources focused on PD although this is a unique mandate of UNFPA within the UN family.

The CO has focused less emphasis and resources on PD although it is the only UN agency with a population mandate and competence. There is need for greater emphasis, increased resources and leverage on PD for enhanced evidence informed advocacy and improved results in all development areas, in line with the 9th and UNFPA Strategic Plan.

Origin: EQ2; Evaluation criteria: Effectiveness; Associated Recommendation: PD R2

Conclusion 3: The CO supported efforts at national and county levels on strengthening M&E, but this function has remained weak and uncoordinated.

Although major strides were made during the 8th CP with the CO supporting efforts at strengthening M&E at national and in the four focus counties, the M&E function in the government remained weak in terms of capacity and coordination mechanisms. Significant effort and resources are required at national level and county levels to strengthen the M&E function and coordination mechanisms within and between the two levels of government.

Origin: EQ2; Evaluation criteria: Effectiveness; Associated Recommendation: PD R3

Conclusion 4: The indicators in the 8th CP aligned are with those of MTPII, but there is lack of clear 'line of sight' between them.

The indicators in the 8th CP M&E framework were generally aligned with high level indicators in the MTP II, but the framework did not expressly include the high level indicators to show clear linkage between them. This is because the PD contributes to the national high level targets through the UNDAF, which was fully aligned with MTPII.

Origin: EQ1; Evaluation criteria: Alignment; Associated Recommendation: PD R4

Conclusion 5: Challenges exist in data availability, especially in humanitarian situations.

There are challenges related to availability of data, especially health related data, for programming and monitoring of results in humanitarian situations. This is a systemic problem within the health system in the country.

Origin: EQ2; Evaluation criteria: Effectiveness; Associated Recommendation: PD R5

Conclusion 6: Initiatives on IMIS and e-Promis have not produced desired results.

Although effort and resources were spent on IMIS and e-Promis, data are incomplete. The former is not operational and appears to lack sufficient government ownership, and the latter is not fully utilized. Investments to date are inadequate to fully operationalize and create demand for these systems.

Origin: EQ2; Evaluation criteria: Effectiveness; Associated Recommendation: PD R6

Chapter Six: Recommendations

Introduction

The recommendations flow directly from the findings and conclusions as indicated by the cross-referencing, and the level of priority is indicated. All recommendations are addressed to the Kenya country office. There are no recommendations to the regional office of UNFPA or headquarters, as there were no major structural methodological constraints, the timing of the CPE was reasonable in terms of planning for the next country programme, despite delays from the original plan, and programming processes were sufficient.

6.1 Strategic Level

Recommendation 1: The 9th CP needs to focus on advocacy, strategic partnerships and innovative resource mobilization to maximize its potential to contribute to strategic outcomes country wide.

The overall focus of the 9th CP must be fully aligned to the changing international and national priorities, utilizing the comparative advantage of UNFPA. Within this framework, the next CP needs to focus primarily on upstream work in line with the lower middle income status of Kenya, declining ODA and regular resources to optimize its added value to achieving results. This means strategic and evidence informed advocacy, capacity to mobilise resources from existing and new sources such as private public partnerships, ensuring high technical competence, and being bold in exploring new modalities for working. Strong attention is needed to measuring cost benefits and risks. An appropriately restructured and streamlined office typology is required with a capacity development strategy for the 9th CP. Also required is a comprehensive advocacy strategy and streamlined and strengthened partnerships and strategic coordination for optimal efficiency gains. Visibility, to promote continued high focus on the UNFPA mandate, should be raised through appropriate branding, key information products, and advocacy in relevant fora.

Priority level: High; Based on strategic conclusion 1

Recommendation 2: The CO needs to avoid spreading itself too thin with financial and technical support for multiple implementation partners, and narrow down support to the most strategic programmes and projects that are demonstrating results.

The CO needs to narrow its support to implementing partners in a strategic manner to minimize the impact of withdrawal of resources and, where possible, assist implementing partners in identifying alternative sources of support. To maximize the benefits from the many current initiatives, especially the RMNCAH and Community Life Centre, close monitoring and evaluation of results and strong reporting are needed, and IP capacity needs to be built to achieve this. Results should be analysed to highlight efficiencies, effectiveness, challenges and potential long-term cost benefits, and be shared as lessons learned to help build capacity within the country for results based programming. In addition, it would be strategic for the CO to support resource mapping in the areas of its mandate, including for gender integration and human rights work, in order to elucidate gaps and where support is most needed.

Priority level: High; Based on strategic conclusion 2

Recommendation 3: In the 9th CP the CO needs to address further the effective dissemination and use of evidence and data at all levels in addition to supporting research and data generation.

The CO needs to make optimal use of its comparative advantage in population data management to ensure data capture across all fields of development, including quantitative and qualitative research data on its areas of mandate (e.g. on socio-cultural values and norms regarding gender and adolescent SRH and on good practice), including in humanitarian situations. Beyond this, the CP need to concentrate more strongly on effective data dissemination modalities, ensuring that information is communicated in user friendly formats and building capacity for the wide

utilization of data at national, county and community level to inform policy, planning and programme implementation, and to generate demand for services. Strengthening use of evidence and data will require a strategy for innovative methods of sharing information to contribute to evidence-informed policy and programming together with stakeholder capacity development.

Priority level: High; Based on strategic conclusion 3

Recommendation 4: The CO needs to assure added value and sustainability of results through effective quality assurance over time.

UNFPA has clearly demonstrated adding value to the policy and strategy environment, mobilizing resources and building capacity and ownership at different levels. To assure sustainability of results the 9th CP needs to incorporate strong quality assurance measures to assess how far these developments are sustained (and sustainable), and translate into significant contributions to outcomes, identifying gaps and challenges that may be addressed.

Priority level: High; Based on strategic conclusion 4

Recommendation 5: The 9th CP needs to be premised on a strong theory of change underlying the results chain logic.

The results chain logic needs to be commensurate with the upstream focus of the CP, with SMART indicators with baseline measurements throughout, and appropriate inputs, activities, interventions and measurable outputs to contribute to measurable outcomes. This will require a strategic results and resources framework and capacity development of the relevant stakeholders, including implementing partners, and the CO in results based management and programming. The RRF should be more inclusive than that of the 8th.

Priority level: Medium; Based on strategic conclusion 5

Recommendation 6: A rights based framework needs to be more clearly articulated to inform the overall programme, with stronger integration of key gender issues also.

Regarding cross-cutting issues, a rights based framework (with focus on duty bearers and rights holders) needs to be elaborated with the requisite capacity development in the CO and among implementing partners for adoption throughout the programming areas of the 9th CP. Consider reverting to the thematic title 'Sexual and Reproductive Health *and Rights*' to reflect this. The gender focus also needs to be more thoroughly integrated throughout.

Priority level: Medium; Based on strategic conclusion 6

6.2 Programme Level

6.2.1 Sexual and Reproductive Health

Recommendation 1: Conduct a full evaluation of the RMNCAH project to identify key lessons that should be systematically applied to the project and contribute to wider national programming for comprehensive SRH, particularly to reduce maternal mortality and teen pregnancy.

The CO and RMNCAH partners should commission an external evaluation of the RMNCAH project to strengthen the overall design of the project, understand its cost benefits, replicability and gaps to inform the next phase, assure sustainability, and assess the potential to expand it into further priority counties. Local capacity of health providers needs to be built to ensure they can fully utilize the available opportunities, the upkeep of equipment and facilities needs to be assured. A clear policy is needed regarding procurement of life saving commodities, and existing tools, such as the RMNCAH Score Card should be fully applied in all counties.

Priority Level: High; Based on SRH conclusion 1

Recommendation 2: Support the scale up and linkage of SRH and GBV interventions in humanitarian responses.

The CO should sustain its humanitarian expertise and advocacy for integrated SRH and GBV responses in humanitarian settings, and leverage further financial and technical resources to strengthen programming on the ground through its key implementing partners.

Priority Level: High; Based on SRH conclusion 2

Recommendation 3: Integrate obstetric fistula management and treatment in routine SRH care and services.

Treatment interventions should be integrated and supported through routine health care in health facilities with special support and training. They should be linked to efforts to prevent obstetric fistula, to raise community awareness and to generate demand through community mobilization and reduce stigma. Results should be closely monitored and evaluated.

Priority Level: Medium; Based on SRH conclusion 3

Recommendation 4: Support the scale up of interventions to address persistent family planning commodity stock-outs.

The CO should support the scale up interventions particularly aimed at addressing FP commodity stock-outs. This should include advocacy for county budgetary allocation for family planning, and support for implementation of FP sustainability strategy and FP Costed Implementation Plans (CIPs) for the counties. Interventions should also include scaling up training on FP commodity quantification and forecasting, demand creation interventions.

Origin: EQ 2; Evaluation criterion: effectiveness; Based on SRH conclusion 4

Recommendation 5: Develop a comprehensive demand creation strategy that is aligned to the strengthening of service provision and is appropriate to the needs of the most vulnerable populations.

The CO and partners should develop a strategy to generate demand for SRH services that outlines interventions aimed at increasing access and utilisation of SRH services and addresses barriers. Demand creation interventions that are built on community engagement and mobilise community structures should be developed and supported by innovative financing options. The needs of particularly vulnerable adolescent girls, sex workers, and those in humanitarian settings should take priority.

Priority Level: High; Based on SRH conclusion 5

Recommendation 6: Develop a branding and communication plan to accompany all SRH interventions in the field.

An information, education, and communication plan that includes UNFPA branding should be an integral part of all SRH interventions, with the aim of communicating the brand and mandate of the organisation. All facility improvements and equipment supply should be easily associated with UNFPA and, by extension, its mandate.

Priority Level: High; Based on SRH conclusion 6

6.2.2 Adolescents and Youth

Recommendation 1: Develop an advocacy and stakeholder engagement plan to address CSE and find common ground for CSE integration in the curriculum.

The CO needs to engage more robustly with the key stakeholders to identify common ground on CSE integration and to build capacity. This should achieve some bottom-line agreements on what to include, age appropriateness of content, and on sensitive terminologies. An advocacy and stakeholder engagement plan should be developed jointly with UNESCO and other interested partners, to reach the Ministry of Education, KICD, faith based organisations and other conservative communities. Such advocacy and stakeholder engagement should be driven by UNFPA at higher leadership and strategic rather than technical level.

Priority Level: High; Based on AY conclusion 1

Recommendation 2: Continue the meaningful engagement of young people in all levels of adolescent and youth programming.

The CO should advocate for strengthened opportunities and platforms for adolescents and young people as effective advocates for their own SRH, for gender equality and to address their rights. This should involve capturing their priorities and insights in developing approaches to stimulate demand creation among their peers and could usefully incorporate a barrier based analysis.

Priority Level: High; Based on AY conclusion 2

Recommendation 3: Build further capacity for integration of youth and gender friendly services within health facilities and closely evaluate the Community Life Centre results.

The CO should leverage resources for greater investment in building the capacity of health care workers and health facilities to provide integrated youth and gender friendly SRH services and to undertake effective community outreach to generate demand. The CLC needs close monitoring and evaluation to assess cost benefits over time.

Priority Level: High; Based on AY conclusion 3

Recommendation 4: Scale up investment in innovations by young people in use of digital and online platforms and other approaches to increase access of information and uptake of SRH services by adolescents and youth.

Because young people spend increasing time on digital and online platforms, including social media, these platforms should be utilized effectively to engage young people. Young people themselves need to be involved in the design of these and other approaches to youth engagement, and implementing partners should be engaged to strengthen M&E of results.

Priority Level: Medium; based on AY conclusion 4

6.2.3 Gender Equality and Women's Empowerment

Recommendation 1: Strengthen collaboration between actors in GBV and FGM/C.

There needs to be enhanced collaboration between actors implementing GBV and FGM/C interventions to allow for greater synergies and efficiency in attaining achievement of desired results, and the potential for mutual learning.

Priority: High; Based on GEWE conclusion 1

Recommendation 2: Sustain and strengthen the capacity and linkages of key actors in GBV and FGM/C and child marriage, and integrate approaches.

Support capacity development of key actors to build transformative community dialogues and strengthen demand for protection against GBV, FGM/C and early marriage. Invest in the formal education curriculum to contribute to long-term change in the values and belief systems of girls and boys. An integrated approach to FGM/C, early marriage and GBV interventions with the SRH and adolescent and youth programmes is recommended.

Priority: High; Based on GEWE conclusion 2

Recommendation 3: Develop a risk and mitigation strategy to address to GBV, FGM/C and wider gender inequalities backed with a high level advocacy campaign.

The CO should develop a risk and mitigation strategy that fully analyses the potential threats to gender and human rights. This should strengthen culturally sensitive approaches and help realise the effective implementation of existing laws and policies and community embeddedness.

Priority: High; Based on GEWE conclusion 3

Recommendation 4: Application of the gender marker should be strengthened.

Barriers to full implementation of the gender marker tool should be explored and resolved so that the gender marker is fully utilized to inform strategic planning and programming.

Priority: High; Based on GEWE conclusion 4

6.2.4 Population Dynamics

6.2.4 Population Dynamics

Recommendation 1: Refocus effort on dissemination and capacity building for effective use of data.

Effort and resources need to be refocused towards timely packaging, dissemination, and capacity building for utilization of data among stakeholders in general and especially at county level. There is an urgent need to prepare the counties early for effective policy formulation, programming and M&E during the 3rd Medium Term Plan (MTP III) of Vision 2030. These includes building capacity of counties to effectively use available data and put in place the necessary policy, regulatory and institutional frameworks early enough to allow for improved governance and results throughout the MTP III period. It is especially important that counties have the capacity to formulate quality CIDPs.

Priority: High; Based on PD conclusion 1

Recommendation 2: Increase emphasis, resources and leverage on the unique mandate and competencies of the CO in PD to support advocacy and results in all focal areas.

In the 9th CP, the CO should invest further in its unique mandate and competencies in PD to enhance its advocacy role and to support the achievement of results, including SRH, AY, FP and gender for its own programmes and to support those of other stakeholders.

Priority: High; Based on PD conclusion 2

Recommendation 3: The CO should work with other partners and increase resources and support for the strengthening of M&E at national and county levels.

UNFPA should work with other UN agencies, multilateral and bilateral partners to strengthen national monitoring and evaluation capacities and systems for improving national and county monitoring, measurement and reporting. The CO should increase resources and strengthen its financial and technical capacity to MED so as to systematically strengthen M&E at national and county levels. In particular, there is need to follow through with the approval in Parliament of the National M&E Policy; provide technical support for the formulation of the Plan of Action to operationalize the National M&E Policy; support the formulation and enactment as early as possible of the M&E Bill; and provide advocacy support for the mobilization of resources at national and county levels for building of the requisite M&E capacities, and the implementation of the necessary institutional frameworks for improved performance and coordination within and between the two levels of government. The 9th CP should also build on the gains of the Health Data Collaborative.

Origin: EQ2; Evaluation criteria: Effectiveness; Associated Recommendation: PD Conclusion 3

Recommendation 4: Consider including high level indicators in the MTPIII in the 9th CP M&E framework.

Although MTP III indicators will be at the broad outcome level which are expected to be fully aligned with those of UNDAF, there is need to include the high level indicators within the 9th CP M&E framework.

Priority: High; Based on PD conclusion 4

Recommendation 5: Take the lead in addressing data needs in humanitarian response situations.

The CO needs to take the lead in fully articulating the challenges related to availability of data, especially health related data, for programming and monitoring of results in humanitarian response situations; and advocating and mobilizing the resources and effort necessary.

Priority: High; Based on PD conclusion 5

Recommendation 6: Mobilize adequate resources to operationalise IMIS and e-Promis.

Resource mobilization and further efforts are needed fully to operationalise the two systems to achieve the desired benefits, establish demand for their outputs and facilitate ownership and sustainability. For IMIS, this requires sufficient technical support and resources to upload all the datasets and ensure the system is up to date, and then train personnel, including in counties, to access the data. For e-Promis, the CO may consider an advocacy role and assist MED to mobilize the necessary resources to fully upload projects data for optimum use of the system for monitoring and accountability.

Priority: Medium; Based on PD conclusion 6

6.3 Lessons Learned

Some key lessons learned from the 8th CP evaluation are:

1. High level lobbying and timely advocacy by the CO based on strategic evidence leveraged significant financial resources and national and county commitment to reduce maternal mortality, and support wider sexual and reproductive health needs.
2. Continued advocacy at different levels, based on continued generation and use of strategic information, and stronger branding are needed to ensure UNFPA retains visibility that is currently declining.
3. With declining international resources it is not strategic and sustainable for the CO to continue to support multiple local implementing partners and local activities. Lessons should be learned from current pilots and other efforts to inform future advocacy, resource mobilization and appropriate technical support.
4. By supporting strategic partnerships, including innovative public-private partnerships and exploring emerging financial opportunities, the CO helped to galvanise the comparative advantage of diverse sectors and generated new opportunities for development.
5. The CO has utilised a critical and focused evidence base on the most vulnerable geographical areas and populations successfully to leverage resource commitment targeted to where it is most needed.
6. Greater CO investment is needed to strengthen access to, understanding and strategic use of information throughout all sectors in order to ensure that the generation of evidence and data leads to evidence-informed policy, planning, programme implementation and monitoring and evaluation.
7. The CO has focused on building national and local capacity for strategic planning, implementation, monitoring and evaluation for output, outcome and impact results. This is an ongoing requirement that needs efficient and effective technical assistance and financial resources, and clear understanding of present resources and responses.

ANNEX 1: Terms of Reference

Terms of Reference

GOK/UNFPA 8TH COUNTRY PROGRAMME 2014 - 2018

COUNTRY PROGRAMME EVALUATION

Contents

Contents

<u>Contents</u>	2
<u>1. Introduction</u>	3
<u>2. Country Context</u>	3
<u>3. UNFPA Programmatic Support to Kenya</u>	6
<u>4. Objectives and Scope of the Evaluation</u>	8
<u>5. Evaluation Criteria and Evaluation Questions</u>	9
<u>6. Methodology and Approach</u>	10
<u>6.1. Approach</u>	10
<u>6.2. Methodology</u>	12
<u>7. Evaluation Process</u>	13
<u>8. Expected Outputs/deliverables</u>	15
<u>9. Workplan/Indicative Timeframe</u>	15
<u>10. Composition of the Evaluation Team</u>	16
<u>11. Qualifications and Experience of the Evaluation Team</u>	16
<u>12. Remuneration and duration of the contract</u>	18
<u>13. Management of the evaluation</u>	18
<u>14. Bibliography and Resources</u>	19

1. Introduction

The 8th Country Programme (2014-2018) of UNFPA support to the Government of Kenya responds to national priorities as articulated in the second Medium Term Plan (MTP II) and the United Nations Development Assistance Framework (UNDAF). The UNDAF is based on four Strategic Results Areas (SRAs) namely: (i) Transformative Governance; (ii) Human Capital; (iii) Sustainable and Equitable Economic Growth; and (iv) Environmental Sustainability, Land Management and Human Security. The SRA's have different goal and outcome level indicators and UNFPA contributes to SRAs (i), (ii) and (iv). As part of the UN reform agenda, the Country Programme (CP) is implemented within the framework of Delivering-as-One.

The 2013 UNFPA Evaluation Policy requires Country Programmes to be evaluated at least once every two cycles and this policy will guide the evaluation process. In addition, the ten general UNEG norms/principles as well as the four institutional norms will be upheld and reflected in the management and governance of the evaluation. According to the UNFPA Strategic Plan 2014-2017 business model, Kenya was assigned the red quadrant as a low income country at the time as a result of which the country programme was designed to apply four programming strategies at the national and sub-county levels, namely: (a) advocacy and policy dialogue/advice, particularly in the 15 counties with the highest burden of maternal mortality; (b) knowledge management; (c) capacity development; and (d) service delivery.

This country programme evaluation will document achievements realized, and be forward looking in identifying opportunities of operationalizing Kenya's Vision as a low middle income country and inform the next country programme. The evaluation will serve the purposes of demonstrating accountability to stakeholders on performance in achieving development results and on invested resources, supporting evidence-based decision making and contributing important lessons learned on how further improve programming.

The evaluation will be conducted by a team of independent evaluators and will be managed by the UNFPA Kenya Country Office, with support provided by ESARO M&E advisor in the various stages of the evaluation process. The primary users of the evaluation results are the UNFPA Executive Board, UNFPA Kenya Country Office, the Government of Kenya, Development Partners and the Implementing Partners. Evaluation findings will be disseminated to these audiences as appropriate and also through other platforms such as social media and websites/ portals.

2. Country Context

The population of Kenya is projected to reach 47,898,083 in 2017 (2009 Population and Housing Census), increasing from 28.7 million in 1999, with an inter-censal population growth rate of 2.9 percent. Sixty-four percent of the population is below 24 years of age, 20.6 percent of whom are youth aged 15 to 24. The GDP in Kenya advanced 6.2 percent year-on-year in the second quarter of 2016, following a 5.9 percent growth in the same period of 2015. It was the highest growth since the third quarter of 2013.

In 2010, Kenya adopted a new constitutional framework that has established a devolved system of governance with 47 counties, introducing a new political and development dimension which continues to influence UNFPA's programming. This constitution also afforded Kenyans the highest attainable right to healthcare including reproductive health.

The maternal mortality ratio (MMR) remains high at 362 deaths per 100,000 live births, a decrease from 488 deaths per 100,000 live births, according to the Kenya Demographic and Health Survey of 2014 and 2008/2009. This national MMR estimate however obscures the disparities at county level where MMR ranges from 187 deaths per 100,000 live births in Elgeyo Marakwet County to 3,795 in Mandera County. The high maternal mortality ratio is due to limited use of skilled care, with only 58 percent of expectant mothers completing the recommended four antenatal care visits and 62 percent receiving skilled care at delivery. For every one maternal death, there are nearly 30 women who suffer severe pregnancy complications including obstetric fistula. The prevalence of obstetric fistula stands at one percent of all women, although there are many unreported cases. The underlying causes for women's low usage of reproductive health care services is to a high extent linked to poverty, distance to quality service clinics, resistance to attend due to negative health staff attitudes and gender inequalities in which women do not have control over their bodies. This situation is further compounded by inadequate implementation of existing policies, guidelines and protocols.

Kenya has an average HIV prevalence rate of 6 percent and with about 1.6 million people living with HIV infection; it is one of the six HIV 'high burden' countries in Africa. The western part of the country including Homa Bay, Siaya and Kisumu are the most affected with HIV with rates of 25.7 percent, 23.7 percent and 19.3 percent respectively. The counties with the lowest infection rates are Wajir, Tana River and Marsabit with respective rates of 0.2 percent, 1 percent and 1.2 percent. The prevalence is highest among key population groups, especially sex workers which is at 29.3% (Kenya AIDS Response Progress Report 2016). Generally, the incidence of HIV infection has declined. However, nearly 51% of the new HIV infections is among young people (15 -24 years) which is equivalent to 36,000 cases annually.

The total fertility rate declined from 4.9 births per women in 2003 to 3.9 births per woman in 2014, a one-child decline in the past 10 years. The use of modern contraceptive methods has increased markedly over the last decade from 32 percent in the 2003 KDHS to 53 percent in 2014. Eighteen percent of currently married women have an unmet need for family planning services, with 9 percent in need of child spacing and 8 percent in need of child limiting. Challenges affecting optimal utilization of family planning include sociocultural factors; inadequate resource allocation to family planning commodities, inadequate capacity to forecast family planning needs, weak supply chain management, and inadequate capacity at the facility level to provide family planning services, particularly long acting and permanent family planning methods and offering services that are deemed unacceptable to the population.

Kenya's young people, especially adolescents (ages 10 to 19), have certain needs and vulnerabilities that warrant attention. Adolescent sexual and reproductive health (ASRH), is a crucial component of lifelong health and wellbeing and contributes to the health of future generations. Results from Kenya's 2014 Demographic and Health

Survey show that facets of ASRH are improving but some areas need further work. Teenage pregnancy remains at a high 18 percent, while unmet need for family planning amongst married women is at 18 percent. Access to family planning is still a challenge, partly due to the lack of comprehensive sexuality education in the school curriculum and low coverage of youth friendly services at 7 percent.

Kenya periodically collects a wealth of population data. However, more in-depth analysis and dissemination are a challenge, and consistent collection and analysis of vital statistics is limited, as demonstrated in the limited registration coverage of births and deaths, at 58 and 47 percent, respectively, the result of a weak civil registration system. Furthermore, the use of data on population dynamics to inform policy formulation, development planning and implementation at national and county levels remains at a low level.

Significant strides have been made within policy and legislative framework on gender equality. However, major gaps exist in implementation. Fourteen percent of women and 6 percent of men age 15-49 report having experienced sexual violence at least once in their lifetime. Overall, 39 percent of ever-married women and 9 percent of men age 15-49 report having experienced spousal physical or sexual violence. Twenty-one percent of women age 15-49 have been circumcised. There is some evidence of a trend over time to circumcise girls at younger ages. Twenty-eight percent of circumcised women age 20-24 were circumcised at age 5-9, as compared with 17 percent of circumcised women age 45-49. There is a progressive decline in female genital mutilation in the last decade.

In the last decade, the country has witnessed an increase in the frequency and severity of natural disasters and recurrent ongoing conflicts. These emerging challenges call for reinforced preparedness and response mechanisms in order to address the potential negative effects on women and young girls on matters of sexual and reproductive health and gender-based violence.

Kenya is known for its entrepreneurial spirit and innovations such as M-Pesa¹²². Various NGO's and social-enterprises are introducing innovations into humanitarian and development programming and shifting away from "doing business as usual" with the aim of improving efficiency, effectiveness and accountability.

The Aid Environment is vibrant and changing. A multitude of traditional and emerging donors as well as philanthropy and private sector, are supporting the Government of Kenya in realizing its Vision 2030. With Kenya reaching Middle Income status however, various donors are gradually changing their development strategies, phasing out their ODA and taking on an "Aid for Trade" agenda. As a result also of the decreasing aid volumes, development agencies are increasingly pressed to clearly demonstrate tangible results and show their relevance and value addition.

¹²² **M-Pesa** (M for mobile, pesa is Swahili for money) is a mobile phone-based money transfer, financing and microfinancing service, launched in 2007 by Vodafone for Safaricom and Vodacom, the largest mobile network operators in Kenya and Tanzania.

UNFPA pro-actively supports UN Kenya Country Team in its efforts to be a successful Delivering as One self-starter and is increasingly aligning and harmonizing operations and programmes with UN sister agencies.

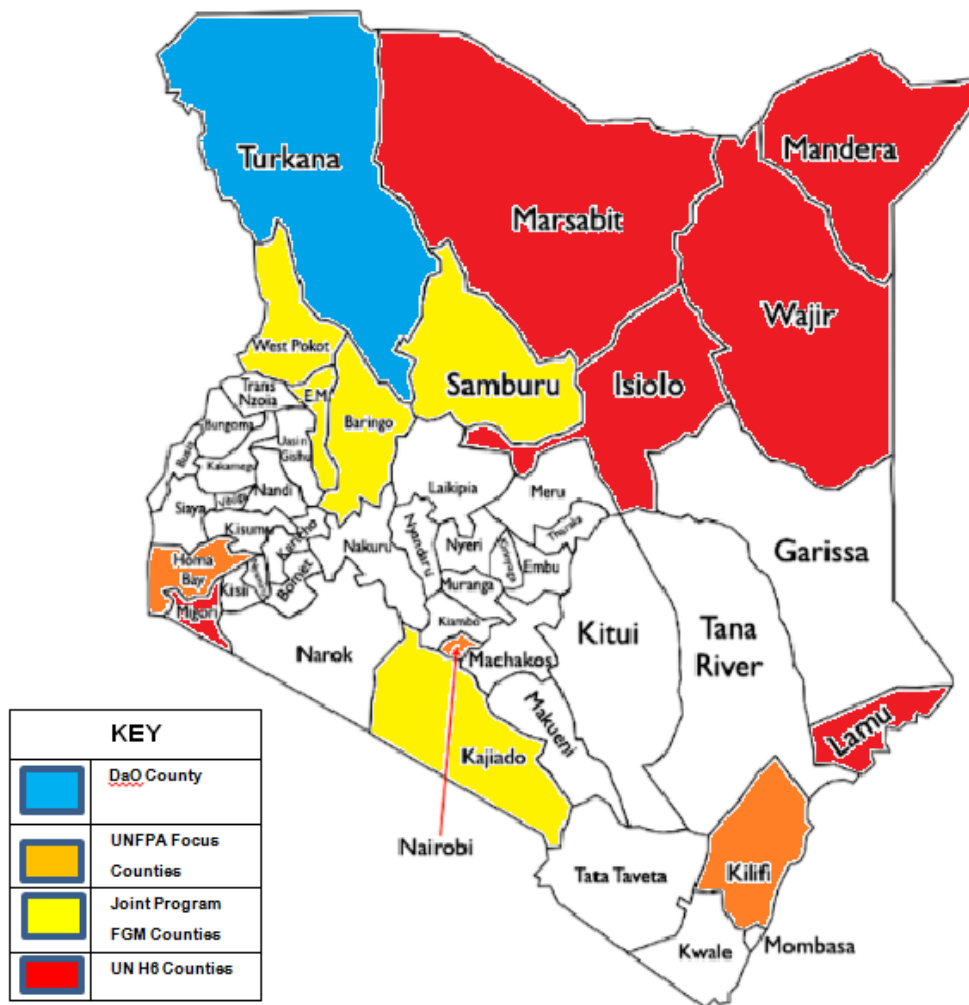
3. UNFPA Programmatic Support to Kenya

UNFPA was established in Kenya in 1972 and has since implemented various five-year programs. It is now in the penultimate year of the eighth country programme (8CP), which covers the period 2014-2018. In the last 45 years, Kenya has responded to the priority needs of Government as articulated in the Medium Term Plans of Vision 2030 and various development policies. The programme was designed to respond to national priorities as articulated in the second medium-term plan, 2013-2017, of the Kenya Vision 2030, and contributes to and aligns with the United Nations Development Assistance Framework, 2014-2018. The programme is likewise aligned with the UNFPA strategic plan, 2014-2017, and grounded in the principles of the International Conference on Population and Development (ICPD), and contributes to the achievement of the Millennium Development Goals.

The eighth country programme, 2014-2018, was formulated in a participatory manner through multi-stakeholder consultations under the leadership of the Government. The programme is to be implemented in collaboration with other United Nations organizations within the framework of 'delivering as one', as well as development partners, non-governmental organizations and private sector institutions.

The country programme contributes to the four UNFPA strategic plan outcomes, 2014-2017, focusing together on the achievement of universal access to sexual and reproductive health and rights. In order to sustain gains achieved during the previous country programme, the programme, in collaboration with other United Nations organizations, supports advocacy for policy implementation and targeted interventions in three of the 47 counties (Homabay, Kilifi and Nairobi in Kasarani sub-county). The programme adheres to the five United Nations programming principles and uses four programming strategies at the national and sub-county levels: (a) advocacy and policy dialogue/advice, particularly in the 15 counties with the highest burden of maternal mortality; (b) knowledge management; (c) capacity development; and (d) service delivery. The programme focuses on adolescents and youth, and women's reproductive health, and is underpinned by human rights, gender equality and population dynamics to deliver on five outputs in line with the cluster approach.

UNFPA KENYA INTERVENTION COUNTIES



The 8th country programme was designed to contribute to national priorities through 4 outcomes of the UNFPA strategic plan 2014-2017, namely:

1. Sexual and reproductive health: Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV that are gender-responsive and meet human rights standards for quality of care and equity in access.

2. Adolescents and youth: Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health.

3. Gender equality and women’s empowerment: Advanced gender equality, women’s and girls’ empowerment, and reproductive rights, including for the most

vulnerable and marginalized women, adolescents and youth.

4. Population dynamics: Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality

The programme was focused on adolescents and youth, and women's reproductive health, underpinned by human rights, gender equality and population dynamics to deliver the following outputs:

1. National and county institutions have capacity to deliver comprehensive integrated maternal and neonatal health and HIV prevention services, including in humanitarian settings (*Sexual and reproductive health*)
2. National and county institutions have capacity to create demand and provide family planning services (*Sexual and reproductive health*)
3. Increased accessibility of comprehensive sexual and reproductive health information and services for young people at national and county levels (*Adolescents and youth*)
4. National and county institutions have capacity to coordinate and implement compliance of obligations on gender-based violence, reproductive health rights and harmful cultural practices (*Gender equality and women's empowerment*)
5. National and county institutions have capacity to generate and avail evidence for advocacy, planning, implementation, monitoring and evaluation of population-related policies and programmes (*Population dynamics*).

4. Objectives and Scope of the Evaluation

The overall **objectives** of the 8th Country Programme Evaluation are:

- (i) to assess the relevance and contribution of the CP to national development results,
- (ii) to enhance accountability of UNFPA and the Kenya Country Office; and
- (iii) to generate a set of clear forward-looking and actionable recommendations logically linked to the findings and conclusions. These recommendations will include specific guidance on the development of the 9th country programme.

Specifically, the CPE aims to:

- (i) To provide an independent assessment of the progress of the programme towards achieving the expected outputs and outcomes set forth in the results framework of the country programme document;
- (ii) To provide an assessment of the Kenya country office's positioning within the developing community and national partners, in view of its ability to respond to national needs while adding value to the country development results;
- (iii) To assess the extent to which the implementation framework enabled or hindered achievements of the results chain i.e. what worked well and what did not work well;
- (iv) To assess the country office monitoring and evaluation system; and

Scope of the Evaluation

The evaluation will cover interventions planned and/or implemented within the current country programme during the period 2014-2017. The evaluation will cover all/the following counties where UNFPA implemented interventions: Homa Bay, Kilifi and Nairobi (Kasarani sub-county, now known as Ruaraka). The evaluation will also tap into the evaluation of the trust fund project "Improving Maternal and Neonatal Outcomes in Six high burden maternal mortality counties in Kenya" that is expected to

take place in 2017. This RMNCAH Project has been implemented in 6 Counties, namely Migori, Isiolo, Wajir, Marsabit, Lamu and Mandera in 2015 and 2016.

The evaluation will cover the technical areas of the CP, namely Sexual and Reproductive Health, Gender Equality and Population Dynamics. In addition, the evaluation will cover cross-cutting aspects such as human rights based approach, gender mainstreaming, coordination, monitoring and evaluation, and partnerships.

- a. Reproductive health with emphasis on:
 - ❖ the supply chain, availability of commodities at service delivery points level,
 - ❖ capacity development for provision of SRH services as well as creation of demand for these services with an emphasis on Family planning services for adolescents girls,
- b. Safeguarding young people including adolescents sexual and reproductive health
- c. Gender, covering aspects of improving a policy environment and building capacities for gender based violence prevention and management
- d. Population and Development, looking at aspects of ensuring availability of disaggregated data, availability and use of evidence for programming and status of population dimension integration in key development policies, plans and frameworks develop during the period under review

5. Evaluation Criteria and Evaluation Questions

In accordance with the methodology for CPEs as set out in the UNFPA Evaluation Office Handbook on How to Design and Conduct Country Programme Evaluations (2013) the evaluation will be based on a number of questions. The evaluators will assess the relevance of the UNFPA country programme including the capacity of the CO to respond to the country needs and challenges. The evaluators will also assess progress in in the achievement of outputs and outcomes against what was planned (effectiveness) in the country programme results and resources framework (RRF) as well as efficiency of interventions in terms of human as well as financial resources and timing concerned and sustainability of results. The indicative questions based on the above four main components are given below:

Relevance	To both national priorities and UNFPA policies and strategies, and how they address different and changing national contexts.
Effectiveness	The extent to which intended outputs have been achieved and the extent to which these outputs have contributed to the achievement of the outcomes.
Efficiency	In terms of how funding, personnel, administrative arrangements, time and other inputs contributed to, or hindered the achievement of results
Sustainability	The extent to which the benefits from UNFPA support are likely to continue, after it has been completed
Added value	The extent to which the UNFPA support adds benefits to the results from other development actors' interventions
Strategic Alignment (Corporate Dimension)	The extent which UNFPA has contributed to the coordination mechanism of the United Nations Country Team, the extent to which the Country Programme is aligned to the UNDAF in the country; and the extent to which the UNFPA Country Office is coordinating with other UN agencies in the country, particularly in the event of potential overlaps.

Responsiveness	The extent to which the CP has the ability to respond to shift in focus in response to external socio-political factors and changes and/or additional requests from national counterparts.
-----------------------	--

The indicative evaluation questions are the following:

Relevance

1. To what extent is the country programme adapted to: national needs and policies; priorities of the programme stakeholders and target groups; the goals of the ICPD Programme of Action, MDGs and SDGs, and the strategies of UNFPA?

Effectiveness

1. To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? Were the planned geographic areas and target groups successfully reached?
2. To what extent has the programme integrated gender and human rights based approaches?

Efficiency

1. To what extent has UNFPA made good use of its human, financial and technical resources to pursue the achievement of the outcomes defined in the county programme?

Sustainability

1. To what extent have UNFPA supported interventions contributed to the development of capacities of its partners?
2. To what extent have the partnerships established by UNFPA promoted the national ownership of supported interventions, programmes and policies?

Added value

1. What are the main comparative strengths of UNFPA in Kenya, and how are these perceived by the national and international stakeholders?
2. To what extent has UNFPA support enabled the different partners (including MDAs, NGOs, communities) improve service delivery or potential to offer services or access to services?

Strategic Alignment (Corporate Dimension)

1. To what extent is the UNFPA Country Office coordinating with other UN agencies in the country, particularly in the event of potential overlaps?

Responsiveness

1. To what extent has the country office been able to respond to changes in national needs and priorities caused or to shifts caused by major political change? What was the quality of the response?

The final evaluation questions and the evaluation matrix will be finalized by the evaluation team in the design report.

6. Methodology and Approach

6.1. Approach

The evaluation will use a theory-based approach. The evaluation team will be expected to reconstruct and understand the logic behind the country programme interventions for the period under evaluation from planning documents and represent it in a diagram to be presented

inception report. The Theory of Change (ToC) reflects the conceptual and programmatic approach taken by UNFPA over the period under evaluation including the most important implicit assumptions underlying the change pathway. The evaluation team will be expected to reconstruct the logic behind the country programme interventions for the period under evaluation from planning documents and represent it in a diagram to be presented in the inception report. The ToC will include the types of intervention strategies or modes of engagement used in program delivery, the principles/guiding interventions, the elements of the intervention logic, the type a level of expected changes and the external factors and influence and determine the causal links depicted in the theory of change diagram. The ToC will be tested during the field and data collection phase.

The evaluation team should use a mixed-method approach including document review, group and individual interviews, focus group discussions, observations and field visits as appropriate. Quantitative methods will encompass compiling and analyzing quantitative secondary data through relevant reports, financial data, and indicator data. Quantitative data will be used to assess trends in programming, investment and outcomes. This information will be complemented by qualitative methods for data collection consisting of document review, interviews, focus group discussions and observations through field visits.

The evaluation should be transparent, inclusive, and participatory, as well as gender and human rights responsive. The evaluation will utilize mixed methods and draw on quantitative and qualitative data. These complementary approaches should be deployed to ensure that the evaluation:

- a) Responds to the needs of users and their intended use of the evaluation results;
- b) Integrates gender and human rights principles throughout the evaluation process, including participation and consultation of key stakeholders (rights holders and duty-bearers) to the extent possible;
- c) Utilize both quantitative and qualitative data collection and analysis methods that can provide credible information about the extent of results and benefits of support for particular groups of stakeholders.

The country programme evaluation will be carried out in accordance with the UNFPA Evaluation Policy.

The work of the evaluation team will be guided by the Norms and Standards established by the United Nations Evaluation Group (UNEG). Team members will adhere to the Ethical guidelines for Evaluators in the UN system and the Code of Conduct, also established by UNEG. The evaluators will be requested to sign the Code of Conduct prior to engaging in the evaluation exercise. The evaluation will also follow the guidance on the integration of gender equality and human rights as established in the UNEG guidance document “Integrating Human Rights and Gender Equality in Evaluations”¹²³.

The evaluation will adopt an inclusive and participatory approach, involving a broad range of partners and stakeholders at both national and sub-national levels. The evaluation will ensure the participation of women, girls and youth in particular those from vulnerable groups of targeted populations.

The evaluation team should perform a stakeholder mapping in order to identify both UNFPA direct and indirect partners (i.e. partners who do not work directly with UNFPA and yet play a key role in a relevant outcome or thematic area in the national context). The stakeholders may include representatives from the government, civil society organizations, the private-sector,

¹²³ See annexes for more information on these documents and guidelines.

UNFPA, peer UN organizations, other multilateral organizations, bilateral donors, and most importantly, the beneficiaries of the programme.

6.2. Methodology

During the design/inception stage, the evaluation team will conduct a comprehensive desk review to define the evaluation design, including data collection and analysis methods and required tools. The proposed methodology is to be outlined in the Design Report prepared by the evaluation team with inputs from the Evaluation Reference Group (ERG).

Data Collection

Data will be collected via multiple approaches including documentary review, group and individual interviews, focus groups and field visits as appropriate. The evaluation will consider both secondary and primary sources for data collection. Secondary sources are used in the desk review which will focus primarily on programme reviews, progress reports, monitoring data gathered by the country office in each of the programme components, evaluation and research studies conducted and large scale and other relevant data systems in - country. Primary data collection will include semi-structured interviews at national and subnational level with government officials, representatives of implementing partners and civil society organizations and other key informants. Field visits will be conducted on sample basis during which focus group discussions will be conducted with beneficiaries and observations will provide additional primary data. Data is to be disaggregated by sex, age and location, where possible.

Data collection methods must be linked to the evaluation criteria, evaluation questions and assumptions that are included within the scope of the evaluation. The evaluation matrix¹²⁴ will be utilized to link these elements together.

The evaluation team is expected to spend 3 weeks in Kenya meeting with stakeholders at national and sub-national levels. The proposed field visit sites and stakeholders to be engaged should be outlined in the inception report together with interview protocols to be submitted by the evaluation team. When choosing sites to visit, the evaluation team should make explicit the reasons for selection. The choice of the locations to visit at sub-national level needs to take into consideration the implementation of UNFPA's program components in those areas and be taken in consultation with the evaluation manager and ERG.

Data Analysis

The focus of the data analysis process in the evaluation is the identification of evidence. The evaluation team will use a variety of both quantitative and qualitative methods to ensure that the results of the data analysis are credible and evidence-based. The analysis will be made at the level of programme outputs and corresponding components and their contribution to outcome level changes.

Evaluation questions set within the change pathway of the ToC will be tested to assess where change has taken place. In the process, the evaluation will assess UNFPA's contribution to the change observed over the years. The reconstructed ToC and the assumptions therein will be tested during the conduct of the evaluation. Judgment will be based on data responding to the

¹²⁴ The evaluation matrix specifies the evaluation; the particular assumptions to be assessed under each question; the indicators, the "sources of information" (where to look for information) that will be used to answer the questions; and the methods and tools for data collection that will be applied to retrieve the data. The evaluation matrix must be included in the design report as an annex. During the field phase, the matrix will be used as a reference framework to check that all evaluation questions are being answered. At the end of the field phase, evaluators will use the matrix to verify that enough evidence has been collected to answer all the evaluation questions. The evaluation matrix must be included in the final report as an annex.

indicators set forward in the evaluation matrix. By triangulating all data from all sources and methods, a comprehensive picture should emerge on the validity of the reconstructed ToC, and UNFPA's contribution to the change observed.

Validation mechanisms

All findings of the evaluation need to be supported with evidence. The evaluation team should use a variety of methods to ensure the validity of the data collected. Besides a systematic triangulation of data sources and data collection methods and tools; the validation of data will be sought through regular exchanges with the UNFPA Kenya Country Office programme managers and other key program stakeholders. Data validation will, moreover, include a validation workshop at the end of the field phase with members of the ERG and other key stakeholders.

Limitations to the methodology

The evaluation team will identify possible limitations and constraints during the data collection phase and present mitigating measures to address them in the inception report.

7. Evaluation Process

The evaluation will unfold in five phases, each of them including several steps. Quality assurance measures should be integrated in all the phases to ensure high quality work.

i) Preparatory Phase

This phase will include:

- Preparation and approval of the Terms of Reference (ToR)
- Constitution of the reference group for the evaluation (ERG)
- Selection, prequalification and hiring of the evaluation team
- Collection of relevant documents regarding the country programme for the period being examined
- A stakeholder map – the Evaluation Manager will prepare a preliminary mapping of stakeholders relevant to the evaluation (to be provided to the evaluation team)

ii) Design Phase

During this phase, the evaluation team will complete:

- A document review of all relevant documents available at the UNFPA Kenya Country Office and UNFPA Headquarters regarding the GoK/UNFPA 8th country programme (2014-2018);
- A stakeholder mapping – The evaluation team, in consultation with the evaluation reference group, will prepare a mapping of stakeholders relevant to the evaluation making use of the initial overview provided by the country office. The mapping exercise will include state, civil society and other relevant stakeholders and will indicate the relationships between different sets of stakeholders;
- Assess limitations to the data collection process and provide mitigation measures.
- An analysis of the results matrix and reconstruction of the intervention logic of the programme i.e. the theory of change meant to lead from planned activities to the intended results of the programme;
- The finalization of the list of evaluation questions;
- Preparation of the evaluation matrix
- The development of a data collection and analysis strategy, as well as a concrete work plan for the field phase

At the end of the design phase, the evaluation team will produce a **design report**, displaying the results of the above-listed steps and tasks¹²⁵. An **evaluation matrix** will accompany the design report, and display the core elements of the evaluation: a) *what* to be evaluated (evaluation criteria, questions and assumptions) and b) *how* to evaluate – the sources of information and methods and tools for data collection.

iii) Field Phase

The evaluation team will undertake a three-week in-country mission to collect and analyze the data required in order to answer the evaluation questions consolidated at the design phase. Field work will start with a briefing to CO staff on the evaluation.

At the end of the field phase, the evaluation team will provide the CO with a debriefing presentation on the preliminary results of the evaluation, with a view to validating preliminary findings and testing tentative conclusions and/or recommendations.

iv) Reporting Phase

During this phase, the evaluation team will continue the analytical work initiated during the field phase and prepare a **first draft of the final evaluation report**¹²⁶, taking into account comments made by the Country Office at the debriefing meeting. This first draft final report will be submitted to the Evaluation Reference Group for comments (in writing) while respecting the independence of the evaluation team in expressing its judgment. The Evaluation Manager in coordination with the Regional M&E advisor will use the Evaluation Quality Assessment Grid¹²⁷ to assess the quality of the draft evaluation report.

Comments made by the reference group, and consolidated by the Evaluation Manager will then allow the evaluation team to prepare a **second draft of the final evaluation report**. This second draft report will form the basis of a validation and dissemination seminar, which should be attended by the country office, as well as all the key programme stakeholders (including key national counterparts).

The **final report** will be drafted shortly after the seminar, taking into account comments made by the participants.

v) Management response and follow up

The Reporting Phase closes with the three-stage evaluation quality assessment (EQA) of the final evaluation report. The EQA process involves: (a) a quality assessment of the final evaluation report by the CO evaluation manager; (b) a quality assessment by the regional monitoring and evaluation adviser; (c) a final independent quality assessment by the Evaluation Office.

During this phase, the country office will prepare a management response¹²⁸ to the evaluation.

The final evaluation report, along with the management response, and EQA of the report will be published in the UNFPA evaluation database. The evaluation report will also be made available to the UNFPA Executive Board and will be widely distributed within and outside the organization.

¹²⁵ For the design report template, see annexes.

¹²⁶ The evaluation report template is outlined in the annexes.

¹²⁷ See annexes

¹²⁸ See annexes

8. Expected Outputs/deliverables

The evaluation will be expected to produce the following deliverables:

- A design/inception report including (as a minimum): (a) a stakeholder mapping; (b) the evaluation matrix (including the final list of evaluation questions and indicators); (c) the overall evaluation design and methodology, with a detailed description of the data collection plan for the field phase;
- Debriefing presentation documents (Power Point) synthesizing the evaluation design and later on, main preliminary findings, conclusions and recommendations of the evaluation, to be presented and discussed with the country office during the debriefing meeting foreseen at the end of the field phase;
- A final evaluation report (potentially followed by a second draft, taking into account comments from the evaluation reference group);
- A PowerPoint presentation of the results of the evaluation for the validation and dissemination seminar
- A final report, based on recommendations from the validation and dissemination seminar.

9. Workplan/Indicative Timeframe

CPE Phase and Task	January				February				March				April				May				June			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Preparatory Phase																								
Drafting of the Terms of Reference	■	■																						
Review and approval of Terms of Reference by ESARO and EO			■	■	■	■																		
Pre-qualification of consultants						■	■																	
Recruitment of the evaluation team									■	■														
Design Phase																								
Evaluation Reference Group (ERG) meeting											■													
Understanding of the UNFPA strategic response, programmatic response											■													
Submission of design/inception report by the evaluation team												■												
Field Phase																								
Data collection, analysis and debriefing														■	■	■								
Reporting phase																								
1 st draft final report																			■					
ERG meeting																			■					
Feedback to draft report																			■					
2 nd draft final report																				■				
Feedback on 2 nd draft final report																				■				
Final report																					■			
Dissemination and management response																								
Quality assessment of final report																						■		
Dissemination among stakeholders																							■	
Management response preparation																							■	

10. Composition of the Evaluation Team

The evaluation will preferably be conducted by an evaluation team comprised of a team leader and three experts with expertise to cover each of the thematic area: i.e a technical expert for each thematic programme area – reproductive health and adolescent and youth, population and development, and gender.

Roles and Responsibilities of the evaluation team

- The team leader will be overall responsible for the evaluation process and the production of the draft and final evaluation reports. S/he will lead and coordinate the work of the evaluation team during all phases of the evaluation and be responsible for the quality assurance of all evaluation deliverables. She/he will liaise with the Evaluation Manager at the CO on various issues related to successful completion of the evaluation exercise.
- The Team Leader will have the requisite expertise in the development field and be experienced in conducting complex type of evaluations, like country programme evaluations, partnership evaluations, strategic evaluations, thematic multi-country evaluations. She/he will have overall responsibility for providing guidance and leadership in: development of the evaluation design including approach, methodology and workplan; drafting the design, draft and final reports, as well as brief summary for presentation at a dissemination workshop. The team leader will lead the CPE process and will provide guidance to the other team members.
- A sexual and reproductive health expert (Consultant) will provide expertise in sexual, reproductive and maternal health (including family planning, HIV prevention, and human resource management in the health sector) and adolescent health. She/he will take part in the data collection and analysis work during the design and field phases. She/he will be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to reproductive health and rights.
- A population expert (Consultant) will provide expertise in population and development issues (including census, democratic governance, population dynamics, monitoring and evaluation, legal reform processes, national and local capacity development and the national statistical system). She/he will take part in the data collection and analysis work during the design and field phases. She/he will be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to population and development.
- A gender expert (Consultant) will provide expertise in gender equality issues (women and adolescents reproductive rights, prevention of discrimination and violence against women, etc). She/he will take part in the data collection and analysis work during the design and field phases. She/he will be responsible for drafting key parts of the design report and of the final evaluation report, including (but not limited to) sections relating to the national context and gender equality.

11. Qualifications and Experience of the Evaluation Team

Team Leader

- An advanced degree in Social Sciences, Population Studies, Statistics or Demography.
- 10 years' experience in conducting complex evaluations in the field of development aid for UN agencies and/or other international organizations including experience in leading evaluations
- Substantive knowledge of sexual and reproductive health, population and development and gender equality

- Good knowledge of Kenya's national development context
- In-depth knowledge of evaluation methods, data collection and analysis
- Excellent data analysis skills in qualitative and quantitative methods;
- Experience in carrying out country programme evaluations
- Familiarity with UNFPA or UN operations;
- Proven evaluation team leader experience
- Excellent analytical, writing and communication skills
- Experience working with a multi-disciplinary team of experts
- Excellent written and spoken English
- Where languages other than English (Kiswahili), will be used the team leader will be assisted by subject matter experts, during the field phase for the conduct of the evaluation.”

Sexual and reproductive health expert

- An advanced degree in Medicine, Health Economics, Epidemiology or Biostatistics.
- Specialization in public health;
- 7 years' experience in conducting evaluations in the field of development aid for UN agencies and/or other international organizations;
- Substantive knowledge of sexual and reproductive health as a thematic area
- Good knowledge of the national development context
- Knowledge of evaluation methods, data collection and analysis
- Excellent data analysis skills in qualitative and quantitative methods.
- Familiarity with UNFPA or UN operations;
- Excellent analytical, writing and communication skills
- Experience of operations and response to humanitarian/crisis an advantage
- Ability to work with a multi-disciplinary team of experts
- Ability to provide deliverables on time
- Excellent written and spoken English Language skills and spoken Kiswahili Language skills.
-

Population expert

- An advanced degree in Population studies, Statistics or Demography.
- 7 years' experience in conducting evaluations in the field of development aid for UN agencies and/or other international organizations;
- Substantive knowledge of Population and development as a thematic area
- Good knowledge of the national development context
- Knowledge of evaluation methods, data collection and analysis
- Excellent data analysis skills in qualitative and quantitative methods.
- Familiarity with UNFPA or UN operations;
- Excellent analytical, writing and communication skills
- Experience of operations and response to humanitarian/crisis an advantage
- Ability to work with a multi-disciplinary team of experts
- Ability to provide deliverables on time
- Excellent written and spoken English Language skills and spoken Kiswahili Language skills.

Gender and Development expert

- An advanced degree in Gender and Development, Sociology, Social Work.
- 7 years' experience in conducting evaluations in the field of development aid for UN agencies and/or other international organizations;
- Substantive knowledge of Gender Equality as a thematic area
- Good knowledge of the national development context
- Knowledge of evaluation methods, data collection and analysis
- Excellent data analysis skills in qualitative and quantitative methods.
- Familiarity with UNFPA or UN operations;

- Experience of operations and response to humanitarian/crisis an advantage
- Ability to work with a multi-disciplinary team of experts
- Ability to provide deliverables on time
- Excellent written and spoken English Language skills and spoken Kiswahili Language skills.

12. Remuneration and duration of the contract

Repatriation of workdays among the team of experts will be the following:

	Team Leader	SRH Expert	Population Expert	Gender Expert	Equality
Design phase	8	3	3	3	
Field phase	21	21	21	21	
Reporting phase	21	10	10	10	
Dissemination including stakeholder meeting	1	1	1	1	
TOTAL (days)	50	35	35	35	

The consultants will be paid an agreed daily rate within the UN consultants scale based on qualification and experience. Workdays will be distributed between the date of contract signature and end date of evaluation.

Payment fees will be based on the delivery of outputs, as follows:

- Upon approval of the design report;
20%
- Upon satisfactory contribution to the draft final evaluation report;
40%
- Upon satisfactory contribution to the final evaluation report;
40%

Daily subsistence allowance (DSA) will be paid per nights spent at the place of the mission following UNFPA DSA standard rates. Travel costs will be settled separately from the consultancy fees.

13. Management of the evaluation

The CPE will be conducted by the evaluation team and overall managed by the **Evaluation Manager** of the UNFPA Kenya CO. The evaluation manager will oversee the entire process of the evaluation, from its preparation to the dissemination of the final evaluation report and manage the interaction between the team of evaluators and the reference group. He will serve as an interlocutor between evaluation team and the ERG and facilitate and provide general and logistical support as needed for the evaluation. The evaluation manager will ensure the quality control of deliverables submitted by the evaluation team throughout the evaluation process, communicate this through the EQA process in collaboration with the ESARO M&E advisor and prevent any attempts to compromise the independence of the team of evaluators during the evaluation process.

As per UNFPA's evaluation handbook an **Evaluation Reference Group** (ERG) will be put in place and be tasked to provide constructive guidance and feedback on implementation and products of the evaluation, hence contributing to both the quality and compliance of this exercise.

The reference group will be composed of the evaluation manager and other relevant representatives from the UNFPA country office in Kenya, the National Council for

Population and Development (NCPD), Ministry of Health, State Department of Gender Affairs, Population Studies and Research Institute (PSRI), Federation of Women Lawyers (FIDA-Kenya), the UNFPA ESARO. The main functions of the reference group will be:

- To discuss the terms of reference drawn up by the Evaluation Manager;
- To provide the evaluation team with relevant information and documentation on the programme;
- To facilitate the access of the evaluation team to key informants during the field phase;
- To discuss the reports produced by the evaluation team;
- To advise on the quality of the work done by the evaluation team;
- To assist in feedback of the findings, conclusion and recommendations from the evaluation into future programme design and implementation.

The roles and responsibilities of the **Regional M&E advisor** are:

- Provides support (backstopping) to evaluation manager at all stages of the evaluation;
- Reviews and provides comments to the ToR for the evaluation;
- Assists the CO evaluation manager in identifying potential candidates and reviews the summary assessment table for consultants prior to it being sent to the EO;
- Undertakes the EQA of the draft final evaluation report;
- Provides support to the dissemination of evaluation results.

The roles and responsibilities of the **HQ Evaluation Office** are:

- Approves ToR for the evaluation after the review and comments by the regional M&E adviser (to be included in the draft ToR sent to the EO);
- Pre-qualifies consultants;
- Undertakes final EQA of the evaluation report;
- Publishes final report, EQA and management response in the evaluation database.









14. Bibliography and Resources

The following documents will be provided to the consultants at the beginning of the evaluation

1. UNFPA Strategic Plan (2014-2017)
2. UNFPA Strategic Business Plan
3. Kenya Country Office Annual Results Plans (2014, 2015, 2016)
4. Kenya Common Country Complementary Analysis
5. Kenya UNDAF (2014-2018)
6. GOK/UNFPA 8th Country Programme Document (2014-2018)
7. Relevant national policy documents for each programmatic area
8. Kenya Vision 2030, MTP II
9. UNFPA Kenya Resource Mobilization Strategy (2014 – 2018)
10. Implementing Partner and CO Work plans
11. Implementing Partner Progress (Work plan) Reports
12. Country Office Annual Reports (COARs)
13. Improving Maternal and Neonatal Outcomes in Six High Burden Maternal Mortality Counties in Kenya – Project Document
14. Joint Programme Documents
15. Reports on core and non-core resources
16. Table with the list of Atlas projects
17. GOK/UNFPA 7TH Country Programme Evaluation Report
18. Joint Evaluation of Joint Gender Programmes in the UN System –Kenya Summary Case Study Report, 2013

19. Evaluation of UNFPA support to population and housing census data to inform decision-making and policy formulation - Kenya Country Case Study Report - 2015
20. UNICEF Joint Programme on Female Genital Mutilation/Cutting (FGM/C): Accelerating Change - Kenya Country Case Study Report - 2013
21. UNFPA Support to Maternal Health (2000-2011) - Kenya Country Case Study, 2012
22. Evaluation of the Gender Based Violence Information Management System (GBVIMS), 2014
23. Mid Term Review of the Kenya United Nations Development Assistance Framework (UNDAF) 2014-2018, 2016
24. Mid Term Review of the Kenya Health Sector Strategic and Investment Plan (KHSSP, July 2014-2018)
25. NEX audit reports (2014, 2015, 2016) and SPOT Checks Reports (2016)
26. GoK/ UNFPA 8th Country Programme Needs Assessment Report (2014-2018)
27. Assessment and documentation of UNFPA's Advocacy Campaign to End Preventable Maternal Mortality in 15 Counties with the Highest Burden of Maternal Mortality in Kenya (2016).
28. UNFPA 8th Country Programme Media and Communication assets (incl website, OpEds etc).
29. Quarterly workplan monitoring visits reports for all Implementing Partners in all the programmatic areas
30. Macro and Micro assessment reports of Implementing Partners
31. MDG country reports
32. Documentation regarding joint programmes
33. Documentation regarding joint working groups, corresponding meeting agendas and minutes
34. Documentation on donor coordination mechanisms:
 - ❖ List of donor coordination groups in which UNFPA participates
 - ❖ Corresponding meeting agendas and minutes
 - ❖ Co-financing agreements and amendments
35. Handbook on 'How to Design and Conduct a Country Programme Evaluation at UNFPA'
36. UNEG Code of Conduct (2008)
37. UNEG Ethical guidelines (2008)
38. UNEG Guidance document – Integrating Human Rights and Gender Equality in Evaluations (2014)
39. UNEG Norms and Standards (2016)

ANNEXES To TOR

1.	Ethical Code of Conduct of UNEG/ UNFPA Evaluations	 Ethical Code of Conduct for UNEG.do
2.	List of Atlas projects for the period under evaluation	 Template 3- List of Atlas Projects by CPAI
3.	Information on main stakeholders by areas of interventions	 Tool 4 - Stakeholders Mapping Table.docx
4.	Short outlines of the design and final evaluation reports	 Template 8- The Design Report Structu
		 Template 10- Structure of Final Rep
5.	Evaluation Quality Assessment template and explanatory note	 Template 13-Evaluation Quality
6.	Management response template	 Team Central Management Respon:
7.	Evaluation Matrix Template	 Template 5-The Evaluation Matrix.docx

ANNEX II

General Terms and Conditions of Individual Consultant Contracts

United Nations Population Fund

General Terms and Conditions of Individual Consultant Contracts

1. Legal Status: The individual consultant (the “Contractor”) shall have the legal status of an independent contractor vis-à-vis the United Nations Population Fund (“UNFPA”), and shall not be regarded, for any purposes, as being either a “staff member” of UNFPA or the United Nations, under the United Nations Staff Regulations and Rules, or an “official” of the United Nations, for purposes of the Convention on the Privileges and Immunities of the United Nations, adopted by the General Assembly of the United Nations on 13 February 1946. Accordingly, nothing within or relating to the Individual Consultant Contract (the “Contract”) shall establish the relationship of employer and employee, or of principal and agent, between the United Nations and the Contractor. The officials, representatives, employees or subcontractors of UNFPA and of the Contractor, if any, shall not be considered in any respect as being the employees or agents of the other, and UNFPA and the Contractor shall be solely responsible for all claims arising out of or relating to its engagement of such persons or entities.

2. Standards of Conduct: *In General:* The Contractor shall neither seek nor accept instructions from any authority external to UNFPA in connection with the performance of its obligations under the Contract. Should any authority external to UNFPA seek to impose any instructions on the Contractor regarding the Contractor’s performance under the Contract, the Contractor shall promptly notify UNFPA and shall provide all reasonable assistance required by

UNFPA. The Contractor shall not take any action in respect of its performance of the Contract or otherwise related to its obligations under the Contract that may adversely affect the interests of UNFPA, and the Contractor shall perform its obligations under the Contract with the fullest regard to the interests of UNFPA and the United Nations. The Contractor warrants that it has not and shall not offer any direct or indirect benefit arising from or related to the performance of the Contract or the award thereof to any representative, official, employee or other agent of UNFPA. The Contractor shall comply with all laws, ordinances, rules and regulations bearing upon the performance of its obligations under the Contract.

Prohibition of Sexual Exploitation and Abuse: In the performance of the Contract, the Contractor shall comply with the standards of conduct set forth in the Secretary-General's bulletin ST/SGB/2003/13 of 9 October 2003, concerning "Special measures for protection from sexual exploitation and sexual abuse". In particular, the Contractor shall not engage in any conduct that would constitute sexual exploitation or sexual abuse, as defined in that bulletin.

In the performance of the Contract, the Contractor shall comply with the regulations set forth in ST/SGB/2002/9 entitled "Regulations Governing the Status, basic Rights and Duties of Officials other than Secretariat Officials, and Experts on Mission".

The Contractor shall not engage in any corrupt, fraudulent, collusive, coercive, obstructive or unethical practices. The Contractor agrees to bring allegations of corrupt, fraudulent, collusive, coercive, obstructive or unethical practices arising in relation to this Agreement, of which IP has been informed or has otherwise become aware, promptly to the attention of the Director, Office of Audit and Investigation Services, UNFPA. For purposes of this Contract, the following definitions shall apply:

- (i) "corrupt practice" means the offering, giving, receiving, or soliciting, directly or indirectly, of anything of value to influence improperly the actions of another party;
- (ii) "fraudulent practice" means any act or omission, including misrepresentation, that knowingly or recklessly misleads, or attempts to mislead, a party to obtain a financial or other benefit, or to avoid an obligation;
- (iii) "collusive practice" means an arrangement between two or more parties designed to achieve an improper purpose, including influencing improperly the actions of another party;
- (iv) "coercive practice" means impairing or harming, or threatening to impair or harm, directly or indirectly, any party or the property of the party to influence improperly the actions of a party;
- (v) "obstructive practice" means acts or omissions intended to materially impede the exercise of contractual rights of audit, investigation and access to information, including destruction, falsification, alteration or concealment of evidence material to an investigation into allegations of fraud and corruption;
- (vi) "unethical practice" means the conduct or behaviour that is contrary to staff or supplier codes of conduct, such as those relating to conflict of interest, gifts and hospitality, post-employment provisions, abuse of authority and harassment.

The Contractor acknowledges and agrees that any breach of any of the provisions hereof shall constitute a breach of an essential term of the Contract, and, in addition to any other legal rights or remedies available to any person, shall give rise to grounds for termination of the Contract. In addition, nothing herein shall limit the right of UNFPA to refer any alleged breach of the foregoing standards of conduct to the relevant national authorities for appropriate legal action.

3. Title Rights, Copyrights, Patents and other Proprietary Rights: Title to any equipment and supplies that may be furnished by UNFPA to the Contractor for the performance of any obligations under the Contract shall rest with UNFPA, and any such equipment shall be returned to UNFPA at the conclusion of the Contract or when no longer needed by the Contractor. Such equipment, when returned to UNFPA, shall be in the same condition as when delivered to the Contractor, subject to normal wear and tear, and the Contractor shall be liable to compensate UNFPA for any damage or degradation of the equipment that is beyond normal wear and tear.

UNFPA shall be entitled to all intellectual property and other proprietary rights, including, but not limited to, patents, copyrights and trademarks, with regard to products, processes, inventions, ideas, know-how or documents and other materials which the Contractor has developed for UNFPA under the Contract and which bear a direct relation to or are produced or prepared or collected in consequence of, or during the course of, the performance of the Contract, and the Contractor acknowledges and agrees that such products, documents and other materials constitute works made for hire for UNFPA. However, to the extent that any such intellectual property or other proprietary rights consist of any intellectual property or other proprietary rights of the Contractor: (a) that pre-existed the performance by the Contractor of its obligations under the Contract, or (b) that the Contractor may develop or acquire, or may have developed or acquired, independently of the performance of its obligations under the Contract, UNFPA does not and shall not claim any ownership interest thereto, and the Contractor grants to UNFPA a perpetual license to use such intellectual property or other proprietary right solely for the purposes of and in accordance with the requirements of the Contract. At the request of UNFPA, the Contractor shall take all necessary steps, execute all necessary documents and generally assist in securing such proprietary rights and transferring or licensing them to UNFPA in compliance with the requirements of the applicable law and of the Contract. Subject to the foregoing provisions, all maps, drawings, photographs, mosaics, plans, reports, estimates, recommendations, documents and all other data compiled by or received by the Contractor under the Contract shall be the property of UNFPA, shall

be made available for use or inspection by UNFPA at reasonable times and in reasonable places, shall be treated as confidential and shall be delivered only to UNFPA authorized officials on completion of work under the Contract.

4. Confidential Nature of Documents and Information: Information and data that are considered proprietary by either UNFPA or the Contractor or that are delivered or disclosed by one of them (“Discloser”) to the other (“Recipient”) during the course of performance of the Contract, and that are designated as confidential (“Information”), shall be held in confidence and shall be handled as follows. The Recipient of such Information shall use the same care and discretion to avoid disclosure, publication or dissemination of the Discloser’s Information as it uses with its own similar information that it does not wish to disclose, publish or disseminate, and the Recipient may otherwise use the Discloser’s Information solely for the purpose for which it was disclosed. The Recipient may disclose confidential Information to any other party with the Discloser’s prior written consent, as well as to the Recipient’s employees, officials, representatives and agents who have a need to know such confidential Information solely for purposes of performing obligations under the Contract. Subject to and without any waiver of the privileges and immunities of the United Nations, including its subsidiary organs such as UNFPA, the Contractor may disclose Information to the extent required by law, provided that the Contractor will give UNFPA sufficient prior notice of a request for the disclosure of Information in order to allow UNFPA to have a reasonable opportunity to take protective measures or such other action as may be appropriate before any such disclosure is made. UNFPA may disclose Information to the extent as required pursuant to the Charter of the United Nations, resolutions or regulations of the General Assembly, or rules promulgated by the Secretary-General. The Recipient shall not be precluded from disclosing Information that is obtained by the Recipient from a third party without restriction, is disclosed by the Discloser to a third party without any obligation of confidentiality, is previously known by the Recipient, or at any time is developed by the Recipient completely independently of any disclosures hereunder. These obligations and restrictions of confidentiality shall be effective during the term of the Contract, including any extension thereof, and, unless otherwise provided in the Contract, shall remain effective following any termination of the Contract.

5. Travel, Medical Clearance and Service-incurred Death, Injury or Illness: If the Contractor is required by UNFPA to travel beyond commuting distance from the Contractor’s usual place of residence, such travel shall be at the expense of UNFPA and shall be governed by conditions established by UNFPA. Such travel shall be at the least costly airfare structure regularly available or its equivalent when by air.

UNFPA may require the Contractor to submit a statement of good health from a recognized physician prior to commencement of work in any offices or premises of UNFPA or before engaging in any travel required by UNFPA or connected with the performance of the Contract. The Contractor shall provide such a statement of good health as soon as practicable following such request, and prior to engaging in any such travel, and the Contractor warrants the accuracy of any such statement, including, but not limited to, confirmation that the Contractor has been fully informed regarding the requirements for inoculations for the country or countries to which travel may be authorized.

In the event of the death, injury or illness of the Contractor which is attributable to the performance of services on behalf of UNFPA under the terms of the Contract while the Contractor is traveling at UNFPA expense or is performing any services under the Contract in any offices or premises of UNFPA, the Contractor or the Contractor’s dependents, as appropriate, shall be entitled to compensation equivalent to that provided under appendix D to the United Nations Staff Rules.

6. Prohibition on Assignment; Modifications: The Contractor may not assign, delegate, transfer, pledge or make any other disposition of the Contract, of any part thereof, or of any of the rights, claims or obligations under the Contract except with the prior written authorization of UNFPA, and any attempt to do so shall be null and void. The terms or conditions of any supplemental undertakings, licenses or other forms of agreement concerning any goods or services to be provided under the Contract shall not be valid and enforceable against UNFPA nor in any way shall constitute an agreement by UNFPA thereto, unless any such undertakings, licenses or other forms of agreement are the subject of a valid written undertaking by UNFPA. No modification or change in the Contract shall be valid and enforceable against UNFPA unless provided by means of a valid written amendment to the Contract signed by the Contractor and an authorized official or appropriate contracting authority of UNFPA.

7. Subcontractors: In the event that the Contractor requires the services of subcontractors to perform any obligations under the Contract, the Contractor shall obtain the prior written approval of UNFPA for any such subcontractors. The United Nations may, in its sole discretion, reject any proposed subcontractor or require such subcontractor’s removal without having to give any justification therefor, and such rejection shall not entitle the Contractor to claim any delays in the performance, or to assert any excuses for the non-performance, of any of its obligations under the Contract. The Contractor shall be solely responsible for all services and obligations performed by its subcontractors. The terms of any subcontract shall be subject to, and shall be construed in a manner that is fully in accordance with, all of the terms and conditions of the Contract.

8. Use of Name, Emblem, Official Seal or Logo of the United Nations or UNFPA: The Contractor shall not advertise or otherwise make public for purposes of commercial advantage or goodwill that it has a contractual relationship with UNFPA, nor shall the Contractor, in any manner whatsoever, use the name, emblem or official seal of the United Nations, or any abbreviation of the name of the United Nations, or the name or logo of UNFPA in connection with its business or otherwise without the written permission of UNFPA or the United Nations, as applicable.

9. Indemnification: The Contractor shall indemnify, defend, and hold and save harmless UNFPA, and its officials, agents and employees, from and against all suits, proceedings, claims, demands, losses and liability of any kind or nature, including, but not limited to, all litigation costs and expenses, attorney's fees, settlement payments and damages, based on, arising from, or relating to: (a) allegations or claims that the use by UNFPA of any patented device, any copyrighted material or any other goods or services provided to UNFPA for its use under the terms of the Contract, in whole or in part, separately or in combination, constitutes an infringement of any patent, copyright, trademark or other intellectual property right of any third party; or (b) any acts or omissions of the Contractor, or of any subcontractor or anyone directly or indirectly employed by them in the performance of the Contract, which give rise to legal liability to anyone not a party to the Contract, including, without limitation, claims and liability in the nature of a claim for workers' compensation.

10. Insurance: The Contractor shall pay UNFPA promptly for all loss, destruction or damage to the property of UNFPA caused by the Contractor, or of any subcontractor, or anyone directly or indirectly employed by them in the performance of the Contract. The Contractor shall be solely responsible for taking out and for maintaining adequate insurance required to meet any of its obligations under the Contract, as well as for arranging, at the Contractor's sole expense, such life, health and other forms of insurance as the Contractor may consider to be appropriate to cover the period during which the Contractor provides services under the Contract. The Contractor acknowledges and agrees that none of the insurance arrangements the Contractor may make shall, in any way, be construed to limit the Contractor's liability arising under or relating to the Contract.

11. Encumbrances and Liens: The Contractor shall not cause or permit any lien, attachment or other encumbrance by any person to be placed on file or to remain on file in any public office or on file with UNFPA against any monies due to the Contractor or to become due for any work done or against any goods supplied or materials furnished under the Contract, or by reason of any other claim or demand against the Contractor.

12. Force Majeure; Other Changes in Conditions: In the event of and as soon as possible after the occurrence of any cause constituting *force majeure*, the Contractor shall give notice and full particulars in writing to UNFPA of such occurrence or cause if the Contractor is thereby rendered unable, wholly or in part, to perform its obligations and meet its responsibilities under the Contract. The Contractor shall also notify UNFPA of any other changes in conditions or the occurrence of any event which interferes or threatens to interfere with its performance of the Contract. Not more than fifteen (15) days following the provision of such notice of *force majeure* or other changes in conditions or occurrence, the Contractor shall also submit a statement to the United Nations of estimated expenditures that will likely be incurred for the duration of the change in conditions or the event. On receipt of the notice or notices required hereunder, UNFPA shall take such action as it considers, in its sole discretion, to be appropriate or necessary in the circumstances, including the granting to the Contractor of a reasonable extension of time in which to perform any obligations under the Contract.

If the Contractor is rendered permanently unable, wholly or in part, by reason of *force majeure* to perform its obligations and meet its responsibilities under the Contract, UNFPA shall have the right to suspend or terminate the Contract on the same terms and conditions as are provided for below, under "Termination", except that the period of notice shall be five (5) days instead of any other period of notice. In any case, UNFPA shall be entitled to consider the Contractor permanently unable to perform its obligations under the Contract in the case of the Contractor's suffering any period of suspension in excess of thirty (30) days.

Force majeure as used herein means any unforeseeable and irresistible act of nature, any act of war (whether declared or not), invasion, revolution, insurrection, or any other acts of a similar nature or force, provided that such acts arise from causes beyond the control and without the fault or negligence of the Contractor. The Contractor acknowledges and agrees that, with respect to any obligations under the Contract that the Contractor must perform in or for any areas in which UNFPA is engaged in, preparing to engage in, or disengaging from any peacekeeping, humanitarian or similar operations, any delay or failure to perform such obligations arising from or relating to harsh conditions within such areas or to any incidents of civil unrest occurring in such areas shall not, in and of itself, constitute *force majeure* under the Contract.

13. Termination: Either party may terminate the Contract without having to provide any justification therefor upon giving written notice to the other party. The period of notice shall be five (5) calendar days. UNFPA may, without prejudice to any other right or remedy available to it, terminate the Contract forthwith in the event that: (a) the Contractor is adjudged bankrupt, or is liquidated, or becomes insolvent, applies for moratorium or stay on any payment or repayment obligations, or applies to be declared insolvent; (b) the Contractor is granted a moratorium or a stay or is declared insolvent; (c) the Contractor makes an assignment for the benefit of one or more of his or her creditors; (d) a Receiver is appointed on account of the insolvency of the Contractor; (e) the Contractor offers a settlement in lieu of bankruptcy or receivership; or (f) UNFPA reasonably determines that the Contractor has become subject to a materially adverse change in financial condition that threatens to endanger or otherwise substantially affect the ability of the Contractor to perform any of the obligations under the Contract.

In the event of any termination of the Contract, upon receipt by the Contractor of notice of termination issued by UNFPA, the Contractor shall, except as may be directed by UNFPA in the notice of termination or otherwise in

writing: (a) take immediate steps to bring the performance of any obligations under the Contract to a close in a prompt and orderly manner, and in doing so, reduce expenses to a minimum; (b) refrain from undertaking any further or additional commitments under the Contract as of and following the date of receipt of such notice; (c) deliver all completed or partially completed plans, drawings, information and other property that, if the Contract had been completed, would be required to be furnished to UNFPA thereunder; (d) complete performance of the work not terminated; and (e) take any other action that may be necessary, or that UNFPA may direct in writing, for the protection and preservation of any property, whether tangible or intangible, related to the Contract that is in the possession of the Contractor and in which UNFPA has or may be reasonably expected to acquire an interest.

In the event of any termination of the Contract, UNFPA shall only be liable to pay the Contractor compensation on a *pro rata* basis for no more than the actual amount of work performed to the satisfaction of UNFPA in accordance with the requirements of the Contract. Additional costs incurred by UNFPA resulting from the termination of the Contract by the Contractor may be withheld from any amount otherwise due to the Contractor from UNFPA.

14. Non-exclusivity: UNFPA shall have no obligation respecting, and no limitations on, its right to obtain goods of the same kind, quality and quantity, or to obtain any services of the kind described in the Contract, from any other source at any time.

15. Taxation: Article II, section 7, of the Convention on the Privileges and Immunities of the United Nations provides, *inter alia*, that the United Nations, including its subsidiary organs, is exempt from all direct taxes, except charges for public utility services, and is exempt from customs restrictions, duties and charges of a similar nature in respect of articles imported or exported for its official use. In the event any governmental authority refuses to recognize the exemptions of the United Nations, including its subsidiary organs, such as UNFPA, from such taxes, restrictions, duties or charges, the Contractor shall immediately consult with UNFPA to determine a mutually acceptable procedure. UNFPA shall have no liability for taxes, duties or other similar charges payable by the Contractor in respect of any amounts paid to the Contractor under this Contract, and the Contractor acknowledges that UNFPA will not issue any statements of earnings to the Contractor in respect of any such payments.

16. Settlement of Disputes: Amicable Settlement: UNFPA and the Contractor shall use their best efforts to amicably settle any dispute, controversy or claim arising out of the Contract or the breach, termination or invalidity thereof. Where the parties wish to seek such an amicable settlement through conciliation, the conciliation shall take place in accordance with the Conciliation Rules then obtaining of the United Nations Commission on International Trade Law (“UNCITRAL”), or according to such other procedure as may be agreed between the parties in writing.

Arbitration: Any dispute, controversy or claim between the parties arising out of the Contract, or the breach, termination, or invalidity thereof, unless settled amicably, as provided above, shall be referred by either of the parties to arbitration in accordance with the UNCITRAL Arbitration Rules then obtaining. The decisions of the arbitral tribunal shall be based on general principles of international commercial law. For all evidentiary questions, the arbitral tribunal shall be guided by the Supplementary Rules Governing the Presentation and Reception of Evidence in International Commercial Arbitration of the International Bar Association, 28 May 1983 edition. The arbitral tribunal shall be empowered to order the return or destruction of goods or any property, whether tangible or intangible, or of any confidential information provided under the Contract, order the termination of the Contract, or order that any other protective measures be taken with respect to the goods, services or any other property, whether tangible or intangible, or of any confidential information provided under the Contract, as appropriate, all in accordance with the authority of the arbitral tribunal pursuant to Article 26 (“Interim Measures of Protection”) and Article 34 (“Form and Effect of the Award”) of the UNCITRAL Arbitration Rules. The arbitral tribunal shall have no authority to award punitive damages. In addition, unless otherwise expressly provided in the Contract, the arbitral tribunal shall have no authority to award interest in excess of the London Inter-Bank Offered Rate (“LIBOR”) then prevailing, and any such interest shall be simple interest only. The parties shall be bound by any arbitration award rendered as a result of such arbitration as the final adjudication of any such dispute, controversy or claim.

17. Limitation on Actions: Except with respect to any indemnification obligations in Article 9, above, or as are otherwise set forth in the Contract, any arbitral proceedings in accordance with Article 16, above, arising out of the Contract must be commenced within three (3) years after the cause of action has accrued. The Parties further acknowledge and agree that, for these purposes, a cause of action shall accrue when the breach actually occurs, or, in the case of latent defects, when the injured Party knew or should have known all of the essential elements of the cause of action, or in the case of a breach of warranty, when tender of delivery is made, except that, if a warranty extends to future performance of the goods or any process or system and the discovery of the breach consequently must await the time when such goods or other process or system is ready to perform in accordance with the requirements of the Contract, the cause of action accrues when such time of future performance actually begins.

18. Privileges and Immunities: Nothing in or relating to the Contract shall be deemed a waiver, express or implied, of any of the privileges and immunities of the United Nations, including UNFPA.

19. Two or more Currencies: Where two or more currencies are involved, the rate of exchange shall be the United Nations Operational Rate of Exchange on the date UNFPA instructs that payment(s) be effected.

20. Certification of Payment: Any fee payable under this Contract shall be payable only upon certification by UNFPA that Services were satisfactorily performed. For payment of fees in installments, certification by UNFPA that Services were satisfactorily performed is required at each phase. Certification shall be done using such form and format decided by UNFPA. The Contractor may not forward any certification of payment form to the UNFPA finance officer to obtain payment.

21. Electronically scanned copies of signed originals: Electronically scanned copies (*e.g.* “.pdf”) of the signed originals of this Contract shall have the same force and effect as the signed originals thereof.

22. Audit and Investigations:Each invoice paid by UNFPA shall be subject to a post-payment audit by auditors, whether internal or external, of UNFPA or by other authorized and qualified agents of UNFPA at any time during the term of the Contract and for a period of two (2) years following the expiration or prior termination of the Contract. The Contractor further acknowledges and agrees that UNFPA may conduct investigations, at such times as determined solely by UNFPA, relating to any aspect of the Contract or the award thereof, the obligations performed under the Contract, and the operations of the Contractor relating to performance of this Contract. The right of UNFPA to conduct investigations and the Contractor’s obligation to cooperate with such investigations shall not lapse upon expiration or prior termination of the Contract. The Contractor shall provide its full and timely cooperation with any such post-payment audits or investigations. Such cooperation shall include, but shall not be limited to, the Contractor’s obligation to make available any relevant documentation for such purposes at reasonable times and on reasonable conditions. The Contractor shall require its employees, subcontractors and agents, if any, including but not limited to the Contractor’s attorneys, accountants or other advisers, to reasonably cooperate with any post-payment audits or investigations carried out by UNFPA hereunder. UNFPA shall be entitled to a refund from the Contractor for any amounts shown by such audits or investigations to have been paid by UNFPA or used by the Contractor other than in accordance with the terms and conditions of the Contract, including for any amounts paid by UNFPA or used by the Contractor as a result of the Contractor or any of its employees, subcontractors and agents having engaged in any corrupt, fraudulent, collusive, coercive, obstructive or unethical practice (as such terms are defined in Article 2). Such amount may be deducted by UNFPA from any payment due to the Contractor under the Contract.

Annex 2: List of Persons/Institutions Met

Key Informants and Focus Groups

Type of Stakeholder: UN Partners			
Organisation/Agency	Interviewee	Position	Consultant initials
UN RCO	Siddharth Chatterjee Per Knutsson	Resident Coordinator & UNDP Resident Rep Head of UN RCO	HJ HJ
WHO	Rudi Eggers Joyce Lavissa Joseph Chabi	WHO Representative National Professional Officer MNHSRH, ASRH, Gender, Healthy Aging Child and Adolescent Health & Nutrition	HJ
UNICEF	Werner Schultink	Country Representative	HJ
UNAIDS	Jantine Jacobi Ruth Laibun Lisa Ligterink	UNAIDS Country Coordinator Community Mobilisation and Networking Advisor Programme Officer Integrating SRH and Young People	HJ
UN Women	Karin Fueg Kebedeche Nigussie Nyambura Ngugi	Programme Director HeForShe Coordinator H6 Coordinator	HJ DOM DOM
UNESCO	Ann Ndong-Jatta Abdul Rahman Lamin Jane Kamau	Director Social and Human Sciences Specialist HIV & Health Education Programme Officer	HJ HJ DOM
UNHCR	Ivana Unluova	Assistant Representative (Programme)	HJ
Type of Stakeholder: UNFPA Country Office			
Group meeting with management and programme staff with presentations, ERG and DOM, JK, MW			
	Gift Malunga	Deputy Representative, OIC to end June	HJ
	Judith Kunyiha	Assistant Representative	HJ
	Charles Owe	International Operations Manager	HJ
	Ruben Vellenga	Programme Specialist, External Relations and Private Partnerships	HJ
	Florence Gachanja	Programme Specialist, Gender	JK
	Dan Okoro	Programme Specialist, Reproductive Health	DOM, HJ
	Zipporah Gathiti	Programme Specialist M&E	HJ
	Douglas Waudo	Communication Analyst	DOM
	Ezekiel Ngure	Programme Specialist PD	MW
	Marko Lesukat	Humanitarian Specialist	HJ, DOM
	Lilian Langat	Programme Analyst, HIV	DOM
	Rael Mutai	Senior Programme Coordinator	DOM
	Kigen Kipkorir	Programme Officer ASRH	DOM
	Anthony Mutungi	Programme Associate M&E	HJ
	Anne Lindeberg	Programme Specialist	HJ
	Charity Koronya	Programme Specialist RHCS	DOM
	Bashir Issak	Programme Specialist	DOM, HJ
	Jessica Gorham	GBV Regional Advisor	JK
	Administrative staff, SWOT analysis		HJ
	Programme officers, associates and assistants (part questionnaire, part interview)		HJ
Type of Stakeholder: Government of Kenya and Parastatals			
Ministry of Health	Dr. Joel Gondi	Head, RHMSU	DOM
NASCOP	Helgar Musyoki	Key Populations Programme Manager	DOM
NACC	Caroline Ngare	Programme Officer – Development Partners	DOM
State Department of Gender	Mr Komu		JK

Anti FGM Board	Bernadette Loloju	Chief Executive Officer	JK
Office of the Director of Public Prosecutions	Christine Nanjala	Prosecutions office	JK
NCPD	Dr Josephine Kibaru-Mbae Charles Oisebe Nzomo Mulatya Francies Kundu	Director General Communication, Advocacy and Public Education Programme Coordination and M&E Assistant Director, Research	MW/JK/DOM
M&E Department (MED)	Margaret Githinji A M Ratemo	Principal Economist Economist / Statistician I	MW
Kenya National Bureau of Statistics (KNBS)	Michael Musyoka,	Assistant Manager and focal person for UNFPA	MW
Civil Registration Services (CRS)	Judy Kirobi Willy Wambua	Assistant Director	MW
Kenya Institute of Curriculum Development	Jacqueline Onyango	Director, Special Programmes	DOM
Policy Studies and Research Institute (PSRI)	Ben Obonyo	Lecturer and focal person for UNFPA	MW
Kilifi County	Musyoka Simon Mwakisha	Economists, County Planning Department	MW
	Mathenge	Civil Registration Officer	MW
	Gilbert Mwadenje	County Statistical Officer	MW
	Joseph Waema	County M&E	MW
	Team members	County Health Management Team	MW/DOM/JK
Homa Bay County	Ochiel	County Statistical Officer	
	H D Kola	Civil Registration Officer	MW
	Henry Ouma Ojow	County Planning	MW
	James Otiato	RH Coordinator	MW
	Team members	CHMT	DOM/JK/MW
Nairobi County	Daniel Masetu	M&E Director	MW
	Ali Noor	County Planning Department	MW
Wajir County	Team members	CHMT	DOM
Migori County	Team members	CHMT	DOM
Type of Stakeholder: International Development Partners, Donors and Private Sector			
DANIDA	Stefan Andersson	Programme Manager Governance and Health Team	HJ
	Hellen Gesare Bonuke	Programme Officer Governance and Health Team	
DfID	Milke Choge	Health Advisor for DfID Kenya	HJ
USAID	Randolph Augusta	Chief, Health, Population, Nutrition Office	HJ
	Shula Macharia	Senior Health Advisor, Kenya and EA	HJ
Phillips	Eddine Sarroukh	Lead for Health Technologies	HJ
Huawei	Adam Lane	Kenya Lead	HJ
DPHK	Sandra Erikson	Secretary	HJ
CIFF	Nicky Davies	Interim Programme Manager for C4C and In their Hands, ASH Team, Kenya	HJ for DOM
World Vision	Peter Carol Njeri Ndichu	Chairperson, Kasarani GBV network	JK
FIDA Kenya	Alice Maranga	Programme Officer	JK
AMREF	Dr Elizabeth Wala	Programme Director HSS	DOM
Red Cross Kenya	Salima Mohammed	Acting Head of Health	DOM

Africa Coordinating Centre for the Abandonment of FGM/C	Professor Nduva Vera Asubila	Coordinator Programmes	JK
Kenya Healthcare Federation and members	Amit Thakker Marloes Boskser-Kibacha James Kiragu June Omollo Violet Nougyna Sam Sennelo and Rau Menishka	Chair, KHF Projects Coordinator, KHF MSD Kenya Phillips Safaricom MSD Regional Office (by skype)	HJ
Type of Stakeholder: Implementing Partners and Civil Society			
I Choose Life	Phillip Mbithi Eric Nyamwaro Francis Mutua	Programme Officer Programmes & Partnerships Director Chair, Youth Advisory Panel	DOM
NEPHAK	Jane Mutuui Dorcas Khasowa	Programme Manager Programme Office	DOM
FHOK	Amos Simpano	Director of Clinical Services	DOM
	Corazon Ayoma	Youth Project Coordinator	
	Josephine Kimani	FHOK Eastleigh Youth Centre Coordinator	
	Abdilahi Ali	FHOK Malindi Health Centre	
ICHR	Dr. Griffins Mang'uro	Director – Mombasa Office	DOM/JK/MW
IRC	Geoffrey Lutta	RH Technical Coordinator	DOM
	Mercy Lwambi	Women Protection	
Type of Stakeholder: Primary and Secondary Beneficiaries, Focus Group Discussions			
HOMA BAY			
FIDA Kenya	FGD (22)	Law enforcement members	JK
RMNCAH County Officers	FGD (12 officers, 2 per county)	County coordinating officers for reproductive health (5), project coordinators (3), chief nursing officers (2), one director and one deputy director for health	HJ for DOM
World Vision	FGD (24)	GBV Network	JK
NAIROBI			
Adolescents and Youth	FGD (22)	FHOK Eastleigh Youth Centre	DOM
World Vision	FGD (22)	GBV Network members	JK
MIGORI COUNTY			
Community Health Volunteers	FGD (10)	Saro Dispensary	DOM
Nurse Midwives	KII (2)	Saro Dispensary	DOM
KILIFI COUNTY			
Adolescents and Youth	12	Mtwapa ICRH Youth Drop-in centre	DOM/JK/MW
Adolescents and Youth	20	Malindi FHOK Youth Centre	DOM
FSWs	8	Mtwapa Drop-in Centre	DOM/JK/MW
WAJIR COUNTY			
Nurse Midwives	KII (2)	Alimaow Health Centre – Wajir County	DOM

HJ = Helen Jackson, DOM = Dan Onyango-Maina; JK = Jane Kiragu; MW = Martin Wanjohi

ANNEX 3: Documents Consulted

Overarching International, UN, UNFPA and National Documents

1. UNFPA Strategic Plan (2014-2017)
2. UNFPA Strategic Plan (2018-2021) Draft of 10 May 2017
3. UNFPA Strategic Business Plan
4. ICPD Programme of Action, ICPD at 15
5. Kenya Country Office Annual Results Plans (2014, 2015, 2016)
6. Kenya Common Country Complementary Analysis
7. Kenya UNDAF (2014-2018)
8. Constitution of Kenya 2010
9. GOK/UNFPA 8th Country Programme Document (2014-2018)
10. GOK/UNFPA 7th Country Programme Document (2010-2013)
11. GOK/UN Kenya United Nations Development Assistance Framework (UNDAF) 2014-2018
12. GOK/UN Mid Term Review of the Kenya UNDAF 2014-2018 (2016)
13. GOK/UNFPA 7th Country Programme Evaluation Report
14. GoK/UNFPA 8th Country Programme Needs Assessment.
15. Kenya Vision 2030, MTP II
16. UNFPA Kenya Resource Mobilization Strategy (2014 – 2018)
17. Implementing Partner and CO Plans and Reports (COARs), Annual Reports
18. Joint Programme Documents
19. Reports on core and non-core resources
20. Table with the list of Atlas projects
21. NEX audit reports (2014, 2015, 2016) and SPOT Checks Reports (2016)
22. GoK/ UNFPA 8th Country Programme Needs Assessment Report (2014-2018)
23. UNFPA 8th Country Programme Media and Communication assets (website, OpEds etc).
24. Quarterly workplan monitoring visits reports for Implementing Partners across programme areas
25. Macro and Micro assessment reports of Implementing Partners
26. MDG country reports
27. Documentation regarding joint programmes
28. Documentation of joint working groups, corresponding meeting agendas and minutes
29. Documentation on donor coordination mechanisms and groups
30. Corresponding meeting agendas and minutes
31. Co-financing agreements and amendments
32. Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA, latest amendments
33. UNEG Code of Conduct (2008)
34. UNEG Ethical guidelines (2008)
35. UNEG Guidance document – Integrating Human Rights & Gender Equality in Evaluations (2014)
36. UNEG Norms and Standards (2016)

Sexual and Reproductive Health

37. Maternal Mortality in 15 Counties with the Highest Burden of Maternal Mortality in Kenya (2016)
38. Improving Maternal and Neonatal Outcomes in Six High Burden Maternal Mortality Counties in Kenya – Project Document
39. Mid Term Review of the Kenya Health Sector Strategic & Investment Plan (KHSSP, July 2014-2018)
40. UNFPA Support to Maternal Health (2000-2011) - Kenya Country Case Study, 2012
41. UNFPA Kenya (2017): RMNCAH Project Report (July 2015-December 2016)

42. Maryane Waweru-Wanyama (2014): Fistula in Kenya: The Facts and the Needed Approaches. Flying Doctors in Africa
43. Kenya NACC (2016): Kenya AIDS Response Progress Report, 2016
44. GoK MoH (2007). National Reproductive Health Policy: Enhancing Reproductive Health Status for All Kenyans.
45. GoK MoH (2009). National Reproductive Health Strategy: 2009-2015
46. GoK MOH (2009). National Reproductive Health and HIV/AIDS Integration Strategy
47. GoK MoH (2014). National Guidelines on Management of Sexual Violence
48. GoK MoH (2010). National Family Planning Guidelines for Service Providers
49. National AIDS Control Council (NACC) 2014. Kenya National AIDS Strategic Framework 2014/15-2018/19
50. GoK MoH (2012). Towards the Elimination of Mother to Child Transmission of HIV and Keeping Mothers Alive
51. GoK NCPD 2013. Kenya Population Situation Analysis
52. GoK MoH 2016: National Guidelines for Maternal & Perinatal Death Surveillance and Response
53. GoK MoH 2016: National Family Planning Guidelines for Service Providers
54. GoK MoH 2016: Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCAH) Investment Framework

Adolescents and Youth

55. Adolescent and Youth IP Reports 2014-2016
56. CIFF Annual Progress Reports Years I and 2; M&E Plan and Results Tracking
57. C4C Evaluation Report 2017
58. FHOK (2015): Rapid Assessment of Drivers of Teenage Pregnancies in Kasarani Sub-County
59. UNFPA Kenya and ICRH Kenya (2016): Adolescent Sexual Outcomes: Teenage Pregnancies' causes and possible solutions (Kilifi)
60. Population Council (2016): Assessment of vulnerabilities and access to HIV and Sexual and Reproductive health services among in-school and out-of- school young people in Kenya.
61. GoK MoH (2015). National Adolescent Sexual and Reproductive Health Policy
62. GoK MoH (2016). National Guidelines for Provision of Adolescent & Youth Friendly Services
63. GoK MoH 2016: National Policy for the Prevention of HIV Infections Among Key Populations in Kenya
64. The National Council for Law Reporting (2010). The Constitution of Kenya
65. GoK Ministry of Home Affairs, Heritage and Sports (2003) Kenya National Youth Policy
66. GoK (2003). Adolescent Reproductive Health and Development Policy, Nairobi: Ministry of Health.
67. GoK MoH (2007). National Reproductive Health Policy: Enhancing Reproductive Health Status for All Kenyans.
68. GoK MoH (2005). National Guidelines for Provision of Adolescent and Youth Friendly Services in Kenya.
69. UNFPA & International Centre for Reproductive Health (ICRH Kenya) 2016: Adolescent Sexual Outcomes: Teenage Pregnancies' causes and possible solutions

Gender Equality and Women's Empowerment

70. Kenya Country report to CEDAW
71. Joint Evaluation of Joint Gender Programmes in the UN System – Kenya Summary Case Study Report, 2013
72. Joint Programme on Prevention and Response to Gender Based violence 2017-2020
73. Female Genital Mutilation/Cutting Practice in Five selected counties of Kenya, 2016

74. UNICEF Joint Programme on Female Genital Mutilation/Cutting (FGM/C): Accelerating Change - Kenya Country Case Study Report – 2013
75. Annual Report 2015 UNFPA/UNICEF Joint programme on FGM/C: Accelerating change
76. Annual Report 2016, UNFPA-UNICEF Joint programme on FGM/C:
77. UNFPA-UNICEF Joint Programme on FGM/C in Kenya 2016. Champions of Change: Community Voices Driving Campaign against FGM
78. Evaluation of Gender Based Violence Information Management System (GBVIMS), 2014
79. Gender Based Violence in Kenya, The cost of providing services 2016
80. Gender responsive budgeting: Case study of Samburu, Baringo, Homa Bay, Kilifi Counties and Kasarani sub- county 2015
81. Annual Work Plans for ACCAF, FIDA Kenya, World Vision, State Department of Gender/Anti FGM Board and Office of the Director of Public Prosecutions
82. Quarterly and Annual Progress Reports for ACCAF, FIDA Kenya, World Vision, State Department of Gender/Anti FGM Board and Office of the Director of Public Prosecutions
83. UNFPA/ UNICEF, “Female Genital mutilation/Cutting: Accelerating Change: Funding Proposal”, UNFPA, UNICEF, New York, 2007
84. JP.GEWE and National Gender Equality Commission, Gender Based Violence in Kenya a) The cost of providing services; b) The Economic Burden on Survivors.

Population Dynamics

85. Session Paper No 12 on Population Policy for National Development 2012
86. Plan of Action for Population Policy for National Development 2013-2017
87. Kenya Health Sector Strategic Investment Plan 2013-2017
88. Kenya Demographic and Health Surveys 2008/9, 2014
89. 2009 Kenya Population and Housing Census analytical reports
90. Kenya Health Policy 2013-2030
91. State of the World Population 2016
92. State of Kenya Population 2015
93. National Council for Population and Development policy briefs
94. Civil Registration Department Strategic Plan 2013-2017
95. Implementation of MCH Strategy
96. Kenya Vital Statistics Report 2015
97. Draft Kenya National M&E Policy
98. Turkana County Draft M&E Policy
99. Annual work plans for CRS, KNBS, MED, PSRI and NCPD
100. Quarterly and annual progress reports, CRS, KNBS, MED, PSRI and NCPD

Annex Four: Evaluation Matrix

STRATEGIC ALIGNMENT, RELEVANCE AND RESPONSIVENESS			
EQ1:			
a. To what extent is the country programme aligned with: ICPD, MDGs and SDGs; the core strategy of UNFPA			
b. To what extent is the CP aligned with national laws, policies, needs and stakeholder priorities, and has the CO responded to changes in national needs and priorities or major political shifts?			
c. How far did the CO respond to recommendations and lessons learned from the 7 th CP?			
d. How effectively does the CO coordinate with other UN agencies including to deliver as one, particularly in areas of potential overlap?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Assumption 1: The CP is aligned with ICPD, MDGs and SDGs and the core strategy of UNFPA; and the needs of the country and its population, particularly vulnerable groups, were taken into account in the 8th CP.	<ul style="list-style-type: none"> • CP and COARs reflect ICPD, MDG and SDG goals and the core strategy of UNFPA • Evidence of systematic identification of the country's needs prior to the programming of each thematic component of the CP. • The extent to which UNFPA CO has appropriately taken into account the priorities of the Kenya Government and key stakeholders. • Choice of beneficiaries for UNFPA- supported interventions are consistent with identified needs as well as national priorities in the AWP, including women, youth and other vulnerable groups • The CP contributes to building national capacities 	<ul style="list-style-type: none"> • ICPD POA, MDG reports, SDG, UNFPA Strategic Plan 2014-2018 and draft 2018-2021, 8th CPD, COARs, UNDAF and review • GOK/UNFPA 8th CPE, 2014 Needs Assessment Report • National policies/strategy documents (e.g. MTPII, National Population Policy, Draft National Gender Policy, National Adolescent Sexual and Reproductive Health Policy), Kenya Constitution • National and county government staff • UNFPA CO staff 	<ul style="list-style-type: none"> • Document review • KI interviews
Assumption 2: The CO has been able adequately to respond to changes in needs and priorities, and to specific requests from the country counterparts.	<ul style="list-style-type: none"> • The speed and timeliness of response (response capacity) • Adequacy of the response (quality of the response) • Evidence of changes in programme design or interventions reflecting changes in needs of the population and priorities of GoK and stakeholders 	<ul style="list-style-type: none"> • AWP • APR • CO staff • UNCTs • GoK and key partners 	<ul style="list-style-type: none"> • Document review • KI interviews

Assumption 3: The UNFPA has effectively contributed to the UNCT and its effort to achieve the goal of delivering as one	<ul style="list-style-type: none"> Evidence of roles played by UNFPA in UNCT and active participation in UNCT working groups, and exchange of information Evidence of joint programming 	<ul style="list-style-type: none"> Monitoring and evaluation reports Joint programmes and work plans and reports UNCT and programme specialists in UN agencies 	<ul style="list-style-type: none"> Document review KI interviews
EFFECTIVENESS EQ2 : a. How adequate was the results chain logic in each programme area? To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? b. To what extent has the programme integrated the cross-cutting issues of gender and human rights based approaches? c. Were there any unforeseen consequences of the UNFPA programme?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data
Assumption 1: The UNFPA CP planned outputs were successfully achieved and contributed to the outcome results across all thematic areas, with a robust theory of change underlying the results chain logic; and that a limited number of strategic activities led to significant results	<ul style="list-style-type: none"> Extent to which M&E of programme achievements indicate timely meeting of outputs The extent to which outputs in the CP and RRF are likely to have contributed to outcome results 	<ul style="list-style-type: none"> M&E documentation AWPs and APRs Relevant programme, project and institutional reports of stakeholders CO staff GoK, IPs and beneficiaries Site visits 	<ul style="list-style-type: none"> Document review KI interviews Focus group discussions with beneficiaries Observation at facilities
<ul style="list-style-type: none"> Assumption 2: The cross-cutting issues of gender and a rights-based approach are clearly apparent in the implementation of the CP 	<ul style="list-style-type: none"> Evidence of the integration of gender and a rights based approach within the planning, programme and project documents of UNFPA Evidence of the integration of gender and a rights based approach provided by KIs and beneficiaries Evidence of increased incorporation during the 8th CP of gender and a human rights approach in national policies, strategies and plans at national and county levels developed during this period, and in IP programmes and projects 	<ul style="list-style-type: none"> AWPs and APRs CO staff GoK and key partners Key government policies, strategies county levels IP progress reports Beneficiaries 	<ul style="list-style-type: none"> Document review KI interviews FGDs with beneficiaries

Assumption 3: Any unforeseen consequences of the CP have been documented and, where necessary, amendments to the CP are implemented or planned	<ul style="list-style-type: none"> Evidence of unforeseen consequences in programme and project reports and assessments Evidence of unforeseen consequences provided by KIs and/or beneficiaries 	<ul style="list-style-type: none"> AWPs and APRs CO staff GoK and key stakeholders 	<ul style="list-style-type: none"> Document review KI interviews FGDs with beneficiaries
Assumption 4: That the CP contributed to effective coordination between IPs	<ul style="list-style-type: none"> Evidence of effective coordination between IPs to which CO contributed 	<ul style="list-style-type: none"> AWPs, APRs CO, GoK, IP interviews 	<ul style="list-style-type: none"> Document review KI interviews
EFFICIENCY EQ3: <ol style="list-style-type: none"> To what extent has UNFPA made good use of its human, financial and technical resources to pursue the achievement of the outputs and outcomes defined in the country programme? To what extent are results effectively and efficiently measured and contributing to accountability in programming? 			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data
Assumption 1: Implementing partners received UNFPA financial and technical support as planned and in a timely manner	<ul style="list-style-type: none"> The financial resources were received to the level planned in the AWP and in a timely manner Quality technical assistance to build capacity was available to the level planned Evidence that technical assistance increased capacity among recipient stakeholders 	<ul style="list-style-type: none"> AWPs and APRs and IP, GoK reports CO financial reports CO, GoK and IP staff 	<ul style="list-style-type: none"> Document review KI interviews
Assumption 2: Administrative, procurement and financial procedures as well as the mix of implementation modalities led to efficient execution of programme activities.	<ul style="list-style-type: none"> Appropriateness of UNFPA administrative, procurement and financial procedures Appropriateness of IP selection criteria Evidence of successful capacity building initiatives with partners 	<ul style="list-style-type: none"> AWPs APRs CO staff GoK and key partners 	<ul style="list-style-type: none"> Document review KI interviews
Assumption 3: The CO M&E system was efficient and effective in documenting progress on the CP and guiding future implementation	<ul style="list-style-type: none"> M&E system in place M&E reports 	<ul style="list-style-type: none"> M&E reports CO Interviews 	<ul style="list-style-type: none"> Document review KI interviews
ADDED VALUE AND SUSTAINABILITY			

EQ4:			
a. What is the added value of UNFPA in Kenya in relation to other stakeholders and to the achievement of results?			
b. To what extent have UNFPA-supported interventions contributed to capacity development in its implementing partners and communities?			
c. How far has UNFPA successfully promoted national ownership regarding its programme areas?			
Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Assumption 1: The CO has added value to the key stakeholders and to the results in all four programme areas compared with what would have been achieved without it.	<ul style="list-style-type: none"> Extent to which CO contributed to finance and/or technical support to GoK and IPs that would not otherwise have been available for each programme area 	<ul style="list-style-type: none"> AWPs and APRs Office typology and skill areas of staff CO staff GoK and key partners 	<ul style="list-style-type: none"> Document review KI interviews Observation
Assumption 2: CO has contributed in all four programme areas to sustainable capacity development in the GoK and IPs, and among primary beneficiaries	<ul style="list-style-type: none"> Evidence of capacity development initiatives supported by CO and of the likelihood of sustainable results (e.g. staff retention, continued finance, improved quality of service) Evidence of IP resources and capacity to continue and develop relevant programmes and projects Evidence of ongoing benefits after the interventions have ended 	<ul style="list-style-type: none"> AWPs and APRs CO staff GoK and IPs 	<ul style="list-style-type: none"> Document review KI Interviews
Assumption 3: The CO has contributed to increased national ownership in each programme area, and to relevant national policies, strategies and plans as well as the incorporation of population dynamics into wider development policies and programming	<ul style="list-style-type: none"> Evidence of active CO involvement regarding policy, strategy and plan development in its programme areas Evidence in policies, strategies and plans of increased incorporation of the programme areas of the CO 	<ul style="list-style-type: none"> AWPs and APRs National, sectoral and county policies and plans and reports 	<ul style="list-style-type: none"> Document review KI interviews

Annex 5: Evaluation Instruments

KI Interview Semi-Structured Schedule with UNCT (includes some POs)

AGENCY

Person(s), position(s)
.....

Interviewer Date.....

Purpose of interview: UNFPA CP evaluation: (broad areas of strategic alignment, relevance, responsiveness, effectiveness, efficiency, sustainability, added value, coordination and partnerships); SRH, GEWE, PD, M&E, finance

1. Agency function
2. UNFPA strategic positioning, relevance, responsiveness
3. UNFPA effectiveness and level of contribution to UNCT and to DAO, UNFPA added value, sustainability (including M&E and finance)
4. Specific areas of joint work, collaboration, coordination, partnership, overlap, different levels and programme areas

SWOT Analysis

KI Interview Schedule and Questionnaire for RMNCAH County Officers

Group Interview with County Officers for RMNCAH Counties

Preliminary introductions, purpose, confidentiality etc

1. How many of you were involved from the start? Probe re extent of involvement/consultation, what aspects – needs assessment, design of programme, implementation, M&E, sense of ownership
2. How far were primary (adols, women) and secondary (nursing staff etc) beneficiaries consulted prior to the programme on their felt needs?
3. Who (among cty officers) is aware of the needs assessment by UNFPA? Who was involved in it?
4. Who (among cty officers) has been directly involved in the RMNCAH evaluation?
5. Did the programme start on time? If not, what were the reasons for delay?
6. What do you see as the primary SRH related needs in the counties?
7. How far does the RMNCAH address these appropriately?
8. What are the main gaps and challenges?
9. The initial outcome results for the programme appear to be mixed, some areas have improved, some even declined, with most higher in 2015 than 2016. Probe the reasons.
10. How well coordinated is the programme? How could coordination be improved?

SWOT EMPHASISING UNFPA ROLES

11. Greatest strengths of programme overall: design, scope geographically, all levels from demand creation and increased use of services (FP incl adols, HIV, ANC, skilled providers for MN and better referral and facilities)

- 12. Limitations/challenges overall (and how/how far they have been dealt with)
- 13. Opportunities for Phase 2
- 14. Threats for Phase 2

Questionnaire for County RMNCAH Officers

County

Please circle your answers, where 1 = little or no improvement/action
 2 = some improvement/ needs much more
 3 = strong improvement/good

Most important gains through the RMNCAH project for:

Improved quality of RMNCAH services through staff training 1 2
 3

Please say which service areas:

Increased community demand for EmOC/EmONC 1 2
 3

Increased adolescent/youth demand for FP – females 1 2
 3

Increased adolescent/youth demand for FP - males 1 2
 3

Better procurement/supply chain mgt for FP commodities 1 2
 3

Better provision of commodities for EMNOC 1 2
 3

Overall institutional capacity built within the county 1 2
 3

Which areas?

Stronger focus on gender and human rights 1 2
 3

Strengthened overall planning and M&E systems 1 2
 3

- Integrated annual work plans in county 1 2
 3

- Regular use of RMNCAH score cards 1 2
 3

- Vital registration strengthened 1 2
 3

- Greater use of data for planning 1 2
 3

Thank you very much for completing the questionnaire.

Questionnaire for CO Programme Staff (also seven informal interviews)

Schedule also used as basis for operations staff group interview and SWOT

All information is confidential, and no individuals will be identifiable. You do not have to put your name, but it helps me to link responses within a team. Please be as open and honest as you can.

Please underline your response and elaborate where requested and where you would like to.

Please complete on line and return by email as soon as you can to helenj2001zw@yahoo.com

Many thanks indeed for your time.

Name

Team

1. Do interruptions/unanticipated requests arise frequently enough to routinely disrupt your completion of planned tasks day to day? Yes No If yes, briefly say the source(s) of most disruption.
2. How would you describe the supervision you receive – supportive or unduly critical, frequent enough or insufficient.
3. How would you describe the office atmosphere overall, mainly: positive negative
4. How effectively does your team communicate/collaborate? Very well quite well not well
5. In your view, how effective are communications and collaboration across different teams in the office? Very good quite good and largely sufficient insufficient
6. Do you think the weekly office meetings are: efficient effective sufficient? If no to any of these, what improvements or other meetings would you propose?
7. On balance do you like the present open/shared office arrangement? Yes No Why is this?
8. Do you consider your workload: heavy about right too light? How could it be improved (if this is needed)?
9. Are your skills effectively and efficiently utilized? Yes No If no, please elaborate.
10. Have your opportunities for training/capacity building been sufficient? Yes No Please explain, and indicate areas you would like to have training in?
11. If you joined the office during the 8th CP, was your induction very good adequate poor
12. Any other comments you would like to make?

CPE Generic Focus Group Question Guide for Gender Programme Secondary Beneficiaries:

Interviewer

Type of Participants

Location

Date

The session starts with introductions, confirmation of confidentiality and the purpose of the FGD, thanking participants for their time.

The guide provides broad questions around which to probe. After the FGD the interviewer will undertake thematic and content analysis and summarise the main findings, and draw provisional conclusions and recommendations.

1. What type of service or programme did you undergo with the IP

2. To what extent did it solve your problem, was it responsive to your needs
3. How was the intervention/service/programme delivered? What do you think has worked best? What has not worked well?
4. Are there other organisations doing similar work as the IP? Probe: are there areas of synergies, are there different approaches
5. How are gender relations and human rights being influenced by the activities being undertaken? Are there challenges? Are there ways to sustain the positive changes
6. Are these activities/services having a lasting impact on your life
7. If you were to recommend changes or ways to improve the interventions what changes would you make or like to see
8. Any final questions or comments you would wish to add?

Key Informant Generic Semi-Structured Interview Schedule

(Generic Guide to adapt for SRH, ASRH, GEWE and PD programme areas)

Interviewer:		Interview Code:	
Date of Interview:		Programme Area:	
Name(s) of Interviewee:			
Institution/Organisation:		Stakeholder Type:	
Position(s):			

The key function of the semi-structured interview tool is to guide and focus the Key Informant Interviews (KIIs) with an aim to obtaining as much information as possible, while being guided by the interview objectives and the particular evaluation criteria.

This KII Guide is to be used for UNFPA Programme and Management staff, UN Agencies, Development Partners, and Government (National and County) and Civil Society Implementing Partners.

1. General Introduction

- Create human connection. Introduce yourself and purpose of the visit.
- Spend a couple of minutes to understand how the Interviewee is today; ask if the timing of the interview is convenient or problematic in any way; give indication of length of interview (30-45 mins) and ask if that is fine with the time.
- Thank the interviewee for making time for the interview.

2. Purpose/Objective and Context of the Interview

- Clarify briefly the objective of the evaluation (UNFPA Kenya evaluation of the 8th CP)
- Explain the objectives of the interview – to get more information on the work that UNFPA Kenya has done between 2013 and 2017.
- Stress confidentiality of the sources and of the information provided, unless the interviewee agrees to be quoted where absolutely necessary.
- Indicate the focus area – SRH/ASRH/Gender Equality/PD – for orientation purposes:
 - i. **SRH and Adolescents and Young People:** To what extent did UNFPA-supported interventions contribute (or are likely to contribute) to sustainably increase the access to and utilization of high-quality SRH services, particularly in underserved areas, with a focus women and girls, adolescents and young people, and vulnerable groups?
 - ii. **Gender Equality:** How far did UNFPA-supported activities contribute in a sustainable manner to i) the integration of gender equality and the rights of women and girls in

national laws, policies, strategies, and plans; ii) the improvement of the prevention and protection from gender based violence at the national and county levels?

- iii. **Population Dynamics:** To what extent did UNFPA-supported interventions in the field of Population and Development contribute in a sustainable manner to a strengthened framework for the planning and implementation of national development policies and strategies?

3. **Core Interview:**

Focus on the Objectives of the Question rather than the specific questions:

	Objective of the Question	Possible information to be collected/Questions to be Asked	Source of Information
1.	Function of the Institution	a. What is the main function/work of the institution/department? b. How does UNFPA contribute to this function? <ul style="list-style-type: none"> • Finance • Technical assistance • Capacity development 	Government and CSO IPs
2.	Rationale for the project activities undertaken (needs assessments, value added, targeting of the most vulnerable groups, extent of consultation with targeted people, ability and resources to carry out the work, gender sensitivity, etc)	a. How did you decide to undertake this work, what were the indications that it would be effective and would reach the target population? b. Who was consulted regarding the design? c. What other actors have been involved, how does this activity contribute to that of others?	Government and CSO IPs
3.	Relevance of the CP/alignment with: <ul style="list-style-type: none"> - ICPD, MDGs and SDGs - UNFPA Corporate Strategy - National laws, policies, and population needs. - Stakeholder priorities 	To what extent are the CP outputs consistent with : <ul style="list-style-type: none"> - UNFPA's Mandate and policies and strategic Plan - Country priority needs, - Vulnerable populations: who are the vulnerable populations? Is the 8th CP designed to contribute to UNDAF, UNFPA's Strategic Plan and MDGs? - Give specific examples How can you describe your working relationship with the <ul style="list-style-type: none"> - Government (line ministries) - Other development partners (USAID, DFID, DANIDA, SIDA) - Other UN agencies (UNICEF, WHO, UNAIDS) - Other implementing partners (NGOs, FBOs, CSOs) 	UNFPA CO, GoK, CS IPs

		<p>To what extent were the interventions able to reach the intended women and girls, adolescents, young people and vulnerable people? What has been the most successful intervention implemented by UNFPA and why? What programme has not worked well and why?</p>	
4.	<p>Responsiveness to changes in national needs and priorities or major political shifts? Response to recommendations and lessons learned from the 7th CP and MTR of the 8th CP?</p>	<p>How far has the CO responded to changes in national needs and priorities or major political shifts? How far did the CO respond to recommendations and lessons learned from the 7th CP and MTR of the 8th CP?</p>	<p>UNFPA CO GoK and CS IPs</p>
5.	<p>Strategic alignment and coordination with other UN Agencies to deliver as one in areas of potential overlap.</p>	<p>How effectively does the CO coordinate with other UN agencies to deliver as one, particularly in areas of potential overlap?</p>	<p>UNFPA CO UN Agencies, Resident Coordinator Inter-Agency Team Coordinators</p>
6.	<p>Effectiveness of UNFPA-supported interventions in all programmatic areas and how they contribute to the achievement of planned results (outputs and outcomes)</p>	<p>To what extent did the interventions supported by UNFPA in all programmatic areas contribute to the achievement of planned results (outputs and outcomes)? How adequate was the theory of change underlying the results chain logic?</p>	<p>UNFPA CO Government and CS IPs</p>
7.	<p>Effectiveness of the programme in integrating cross-cutting issues of gender and human rights based approaches.</p>	<p>To what extent has the programme integrated the cross-cutting issues of gender and human rights based approaches?</p>	<p>UNFPA CO GoK and CS IPs</p>
8.	<p>Unforeseen consequences of the UNFPA programme.</p>	<p>Were there any unforeseen consequences of the UNFPA programme?</p>	<p>UNFPA CO GoK and CS IPs</p>
9.	<p>Efficiency with which UNFPA has made good use of its human, financial and technical resources to pursue the achievement of the outputs and outcomes defined in the country programme Extent to which results are effectively and efficiently measured and contributing to accountability in programming</p>	<p>To what extent has UNFPA made good use of its human, financial and technical resources to pursue the achievement of the outputs and outcomes defined in the country programme? To what extent are results effectively and efficiently measured and contributing to accountability in programming?</p>	<p>UNFPA CO GoK and CS IPs</p>

10.	<p>The added value of UNFPA in Kenya in relation to other stakeholders and to the achievement of results?</p> <p>Extent to which UNFPA-supported interventions contributed to capacity development in its implementing partners and communities?</p> <p>How far UNFPA successfully promoted national ownership regarding its programme areas (policies, increased capacity and budgetary allocation)?</p>	<p>What is the added value of UNFPA in Kenya in relation to other stakeholders and to the achievement of results?</p> <p>To what extent have UNFPA-supported interventions contributed to capacity development in its implementing partners and communities?</p> <p>How far has UNFPA successfully promoted national ownership regarding its programme areas (policies, increased capacity and budgetary allocation)?</p>	<p>Development Partners GoK and CS Partners</p>

4. Brief SWOT on UNFPA Contributions:

Interrogate further on impressions of Stakeholder on UNFPA

1	Strengths	
2	Weaknesses/limitations	
3	Opportunities	
4	Threats	

5. Any further questions/probes

Annex 6: Atlas Project

Project	Outcome	Description	Area	Year	Fund	Budget	Expenditures	Implementation Rate
KEN08ARH	Outcome 2	ASRH	Adolescents and Youth	2014	RR	28 268	26 556	93.9%
KEN08ARH	Outcome 2	ASRH	Adolescents and Youth	2015	OR	281 970	138 359	49.1%
KEN08ARH	Outcome 2	ASRH	Adolescents and Youth	2015	RR	301 495	305 155	101.2%
KEN08ARH	Outcome 2	ASRH	Adolescents and Youth	2016	RR	126 211	109 895	87.1%
KEN08ARH	Outcome 2	ASRH	Adolescents and Youth	2016	OR	314 229	327 452	104.2%
KEN08ARH	Outcome 2	ASRH	Adolescents and Youth	2017	RR	28 238	-437	-1.5%
KEN08ARH	Outcome 2	ASRH	Adolescents and Youth	2017	OR	356 286	28 844	8.1%
KEN08GEN	Outcome 3	Gender	Gender Equality and Women's Empowerment	2014	RR	28 110	23 450	83.4%
KEN08GEN	Outcome 3	Gender	Gender Equality and Women's Empowerment	2014	OR	126 745	16 563	13.1%
KEN08GEN	Outcome 3	Gender	Gender Equality and Women's Empowerment	2015	OR	38 380	30 424	79.3%
KEN08GEN	Outcome 3	Gender	Gender Equality and Women's Empowerment	2015	RR	363 966	360 154	99.0%
KEN08GEN	Outcome 3	Gender	Gender Equality and Women's Empowerment	2016	RR	149 725	149 456	99.8%
KEN08GEN	Outcome 3	Gender	Gender Equality and Women's Empowerment	2017	RR	27 192	9 159	33.7%
ZZJ29KEN	Outcome 3	Gender	Gender Equality and Women's Empowerment	2014	OR	930 793	785 380	84.4%
ZZJ29KEN	Outcome 3	Gender	Gender Equality and Women's Empowerment	2015	OR	1 138 309	814 680	71.6%
ZZJ29KEN	Outcome 3	Gender	Gender Equality and Women's Empowerment	2016	RR		0	
ZZJ29KEN	Outcome 3	Gender	Gender Equality and Women's Empowerment	2016	OR	787 195	737 332	93.7%
ZZJ29KEN	Outcome 3	Gender	Gender Equality and Women's Empowerment	2017	OR	371 227	34 335	9.2%
KEN08KCO	KCO	KCO	Cross cutting	2014	RR	1 530 870	1 489 030	97.3%
KEN08KCO	KCO	KCO	Cross cutting	2014	OR	50 000	8 610	17.2%
KEN08KCO	KCO	KCO	Cross cutting	2015	OR		-6	
KEN08KCO	KCO	KCO	Cross cutting	2015	RR	2 252 158	2 203 387	97.8%
KEN08KCO	KCO	KCO	Cross cutting	2016	RR	2 570 699	2 550 890	99.2%
KEN08KCO	KCO	KCO	Cross cutting	2016	OR	57 500	47 274	82.2%
KEN08KCO	KCO	KCO	Cross cutting	2017	RR	2 122 109	691 094	32.6%
KEN08KCO	KCO	KCO	Cross cutting	2017	OR	323 530	69 628	21.5%
KEN08POP	Outcome 4	P&D	Population and Dynamics	2014	RR	275 748	268 097	97.2%
KEN08POP	Outcome 4	P&D	Population and Dynamics	2015	OR	369 420	262 505	71.1%

KEN08POP	Outcome 4	P&D	Population and Dynamics	2015	RR	575 900	558 228	96.9%
KEN08POP	Outcome 4	P&D	Population and Dynamics	2016	RR	579 223	575 497	99.4%
KEN08POP	Outcome 4	P&D	Population and Dynamics	2016	OR	98 681	73 733	74.7%
KEN08POP	Outcome 4	P&D	Population and Dynamics	2017	RR	103 690	25 050	24.2%
KEN08POP	Outcome 4	P&D	Population and Dynamics	2017	OR		13 862	
KEN08PCA	PCA	PCA	Programme Coordination Assistance	2015	RR	200 000	199 298	99.6%
KEN08PCA	PCA	PCA	Programme Coordination Assistance	2016	RR	200 000	199 812	99.9%
KEN08PCA	PCA	PCA	Programme Coordination Assistance	2017	RR	200 000	33 251	16.6%
FLA03KEN	Outcome 1	SRH	Sexual and Reproductive Health	2015	OR	46 720	46 725	100.0%
FPRHCKEN	Outcome 1	SRH	Sexual and Reproductive Health	2016	OR	605 537	590 110	97.5%
FPRHCKEN	Outcome 1	SRH	Sexual and Reproductive Health	2017	OR	985 853	62 704	6.4%
HRF01KEN	Outcome 1	SRH	Sexual and Reproductive Health	2016	RR	3 889	3 889	100.0%
KEN08RMD	Outcome 1	SRH	Sexual and Reproductive Health	2015	OR	4 171 662	1 395 352	33.4%
KEN08RMD	Outcome 1	SRH	Sexual and Reproductive Health	2016	OR	5 770 826	5 348 876	92.7%
KEN08RMD	Outcome 1	SRH	Sexual and Reproductive Health	2017	OR	1 111 346	246 085	22.1%
KEN08SRH	Outcome 1	SRH	Sexual and Reproductive Health	2014	RR	1 472 542	1 269 004	86.2%
KEN08SRH	Outcome 1	SRH	Sexual and Reproductive Health	2014	OR	427 674	53 382	12.5%
KEN08SRH	Outcome 1	SRH	Sexual and Reproductive Health	2015	OR	5 199 932	3 412 186	65.6%
KEN08SRH	Outcome 1	SRH	Sexual and Reproductive Health	2015	RR	2 421 473	2 421 911	100.0%
KEN08SRH	Outcome 1	SRH	Sexual and Reproductive Health	2016	RR	1 203 004	1 297 475	107.9%
KEN08SRH	Outcome 1	SRH	Sexual and Reproductive Health	2016	OR	1 222 132	551 704	45.1%
KEN08SRH	Outcome 1	SRH	Sexual and Reproductive Health	2017	RR	71 049	24 774	34.9%
KEN08SRH	Outcome 1	SRH	Sexual and Reproductive Health	2017	OR	677 841	20 579	3.0%
UBRAFKEN	Outcome 1	SRH	Sexual and Reproductive Health	2016	OR	229 505	62 593	27.3%
UBRAFKEN	Outcome 1	SRH	Sexual and Reproductive Health	2017	OR	179 643	7 305	4.1%
UQA63KEN	Outcome 1	SRH	Sexual and Reproductive Health	2014	OR	97 200	77 894	80.1%
UQA63KEN	Outcome 1	SRH	Sexual and Reproductive Health	2015	OR	100 000	59 600	59.6%
ZZT05KEN	Outcome 1	SRH	Sexual and Reproductive Health	2014	OR	201 121	175 448	87.2%
ZZT05KEN	Outcome 1	SRH	Sexual and Reproductive Health	2015	OR	187 500	179 811	95.9%
ZZT05KEN	Outcome 1	SRH	Sexual and Reproductive Health	2016	OR	170 609	165 639	97.1%
ZZT05KEN	Outcome 1	SRH	Sexual and Reproductive Health	2017	OR	64 463	0	0.0%
ZZT06KEN	Outcome 1	SRH	Sexual and Reproductive Health	2014	OR	208 282	176 954	85.0%
ZZT06KEN	Outcome 1	SRH	Sexual and Reproductive Health	2015	OR	154 771	117 308	75.8%
ZZT06KEN	Outcome 1	SRH	Sexual and Reproductive Health	2016	OR	227 558	220 623	97.0%

ZZT06KEN	Outcome 1	SRH	Sexual and Reproductive Health	2017	OR	130 466	1 478	1.1%
----------	-----------	-----	--------------------------------	------	----	---------	-------	------

Annex 7: GoK/UNFPA Kenya 8th Country Programme Results and Resources Framework

<p>National priority: Realizing an issue-based, people-centred, results-oriented and accountable democratic system that respects the rule of law and protects the rights and freedoms of every individual in society (Vision 2030)</p> <p>UNDAF outcome 1.2: By 2017, a democracy in which human rights and gender equality are respected, elected officials are responsive and accountable; citizens and civil society are empowered, responsible and politically/socially engaged; equitable representation is achieved through affirmative action; and the electoral processes are free, fair, transparent and peaceful.</p> <p>UNDAF outcome 1.4: By 2018, development planning and decision-making are evidence and rights-based, supported by a well-established and robust research, monitoring and evaluation culture that guarantees the independence, credibility, timeliness and disaggregation of data, broadly accessible to the intended audience.</p> <p>UNDAF outcome 2.2: By 2018, morbidity and mortality in Kenya are substantially reduced, with improved maternal, neonatal, and child survival, reduced malnutrition and incidence of major endemic and epidemic diseases (malaria, tuberculosis) and stabilized population, underpinned by a universally accessible, quality and responsive health system.</p> <p>UNDAF outcome 2.3: By 2018, Kenya has reduced socioeconomic impact of HIV and societal vulnerability to HIV that is realized by a well-coordinated, effective, efficient and adequately resourced multisectoral response.</p> <p>UNDAF outcome 4.2: By 2018, counties and communities are able to anticipate, prevent and respond effectively to disasters and emergencies.</p>		
UNFPA strategic plan outcome	Country programme outputs	Output indicators
<p>Outcome 1: Sexual and reproductive health (Increased availability and use of integrated sexual and reproductive health services, including family planning, maternal health and HIV, that are gender-responsive and meet human rights standards for quality of care and equity in access)</p> <p><u>Outcome indicators:</u></p> <ul style="list-style-type: none"> • Percentage of births attended by skilled attendant • National contraceptive prevalence rate • HIV prevalence rate among 15 to 24 year olds 	<p><u>Output 1:</u> National and county institutions have capacity to deliver comprehensive integrated maternal and neonatal health and HIV prevention services, including in humanitarian settings</p>	<p><u>Output indicators:</u></p> <ul style="list-style-type: none"> • Percentage of facilities providing basic emergency obstetric and neonatal care in selected counties • Number of retired midwives recruited and train • Number of counties with disaster management plans integrating reproductive health and gender-based violence • Number of fistula cases repaired annually
	<p><u>Output 2:</u> National and county institutions have capacity to create demand and provide family planning services</p>	<p><u>Output indicators:</u></p> <ul style="list-style-type: none"> • Number of new users in modern contraceptive methods in select counties annually • Percentage of health facilities with capacity to provide long-acting family planning methods • Percentage of facilities providing FP services within the HIV care clinics/centres in select counties

<p>Outcome 2: Adolescents and youth (Increased priority on adolescents, especially on very young adolescent girls, in national development policies and programmes, particularly increased availability of comprehensive sexuality education and sexual and reproductive health)</p> <p><u>Outcome indicators:</u></p> <ul style="list-style-type: none"> • Teenage pregnancy rate • Percentage of young people aged 15-24 who correctly identify ways of preventing sexual transmission of HIV 	<p><u>Output 1:</u> Increased accessibility of comprehensive sexual and reproductive health information and services for youth at national and county levels</p>	<p><u>Output indicators:</u></p> <ul style="list-style-type: none"> • Number of young people accessing sexual reproductive health services in select counties annually • Number of national and county institutions with capacity to provide comprehensive sexual reproductive health programmes to young people • Number of youth accessing voluntary HIV counselling and testing
<p>Outcome 3: Gender equality and women's empowerment (Advanced gender equality, women's and girls' empowerment, and reproductive rights, including for the most vulnerable and marginalized women, adolescents and youth)</p> <p><u>Outcome indicators:</u></p> <ul style="list-style-type: none"> • Percentage of women aged 15 to 49 who have experienced physical or sexual violence • Female genital mutilation/cutting prevalence rate 	<p><u>Output 1:</u> National and county institutions have capacity to coordinate and implement compliance of obligations on gender-based violence, reproductive health rights and harmful cultural practices</p>	<p><u>Output indicators:</u></p> <ul style="list-style-type: none"> • Existence of a functional monitoring and evaluation framework to monitor compliance of obligations on gender-based violence Baseline: No Target: Yes • Number of communities that have made public declarations against female genital mutilation/cutting and early marriages in programme areas • Existence of standard operational procedures to provide a coordinated response to gender-based violence in the counties • Per cent of gender-based violence survivors receiving comprehensive package of services in humanitarian settings
<p>Outcome 4: Population dynamics (Strengthened national policies and international development agendas through integration of evidence-based analysis on population dynamics and their links to sustainable development, sexual and reproductive health and reproductive rights, HIV and gender equality)</p> <p><u>Outcome indicators:</u></p> <ul style="list-style-type: none"> • Number of national household surveys • National civil registration coverage of births 	<p><u>Output 1:</u> National and county institutions have capacity to generate and avail evidence for advocacy, planning, implementation, monitoring and evaluation of population-related policies and programmes</p>	<p><u>Output indicators:</u></p> <ul style="list-style-type: none"> • Number of analytical population-related reports (a) generated and (b) disseminated • Civil registration coverage of births • Number of county statistical offices with capacity to avail updated statistical information through the integrated multisectoral information system

Annex 8: Implementation Rate by Programme, Funding Source and Year

Programme Cycle Output/ component	Other Resources		Regular Resources		Total		Impl. Rate
	Budget	Expenditures	Budget	Expenditures	Budget	Expenditures	
Adolescents & Youth	1,119,476	1,068,898	343,615	421,193	1,463,090	1,490,091	102%
2014			22,103	28,510	22,103	28,510	129%
2015	260,603	151,353	157,126	230,610	417,729	381,963	91%
2016	495,552	554,532	136,812	143,720	632,363	698,252	110%
2017 - Mid	363,322	363,013	27,574	18,352	390,895	381,365	98%
Gender Equality	4,149,054	3,572,329	2,971,661	3,052,290	7,120,715	6,624,620	93%
2014	1,484,482	1,166,465	2,044,622	2,252,743	3,529,104	3,419,207	97%
2015	1,400,245	1,186,880	679,221	503,010	2,079,467	1,689,890	81%
2016	817,337	791,007	220,625	270,357	1,037,962	1,061,363	102%
2017 - Mid	446,990	427,978	27,192	26,181	474,182	454,159	96%
Population Dynamics	309,581	276,267	2,102,614	1,829,273	2,412,195	2,105,540	87%
2014			435,034	501,188	435,034	501,188	115%
2015	161,826	65,320	672,164	615,568	833,991	680,887	82%
2016	147,755	210,948	618,796	621,863	766,551	832,811	109%
2017 - Mid			376,620	90,654	376,620	90,654	24%
Programme Coord Assistance		3,251	600,000	647,959	600,000	651,210	109%
2015			200,000	319,852	200,000	319,852	160%
2016		3,251	200,000	203,123	200,000	206,374	103%
2017 - Mid			200,000	124,985	200,000	124,985	62%
SRH	20,902,849	15,012,653	12,859,856	11,939,943	33,762,705	26,952,596	80%
2014	777,759	667,979	2,864,797	2,825,793	3,642,557	3,493,771	96%
2015	9,670,855	6,039,519	4,307,880	4,576,528	13,978,736	10,616,047	76%
2016	7,740,810	6,678,972	3,754,289	3,644,224	11,495,099	10,323,196	90%
2017 - Mid	2,713,425	1,626,184	1,932,889	893,398	4,646,314	2,519,582	54%
Grand total	26,480,960	19,933,400	18,877,745	17,890,658	45,358,705	37,824,057	83%