REPUBLIC OF KENYA

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GOK/UNFPA 7TH COUNTRY PROGRAMME EVALUATION

2009-2013
Final Report

NAIROBI, KENYA

13TH MAY 2013

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MAP OF KENYA


Turkana
Marsabit
Mandera
West Pokot
Samburu
Wajir
Trans Nzoia
Elgeyo Marakwet
Bungoma
Baringo
Isiolo
Uasin Gishu
Busia
Kakamega
Laikipia
Meru
Nandi
Siaya
Vihiga
Kisumu
Tharaka Nithi
Nyandarua
Kericho
Nyeri
Garissa
Nakuru
Kirinyaga
Homabay
Nyamira
Embu
Bomet
Muranga
Kisii
Migori
Kiambu
Narok
Nairobi
Machakos
Kitui
Tana River
Makueni
Lamu
Kajiado
Kilifi
Taita Taveta
Mombasa
Kwale

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ABBREVIATIONS AND ACRONYMS

AEG	Aid Effectiveness Group
AFRIYAN	African Youth and Adolescent Network
ANC	Ante-Natal Care
AOPs	Annual Operation Plans
APR	Annual Programme Reports
AU	African Union
AWP	Annual Work Plans
BCC	Behaviour Change Communication
BEOC	Basic Emergency Obstetric care
BRICS	Brazil, India, China and South Africa
BTL	Bilateral Tubal Ligation
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CBO	Community Based Organisations
CDN	Catholic Diocese Nakuru
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CEmOC	Comprehensive Emergency Obstetric Care
CHWs	Community Health Workers
CIPK	Council of Imams and Preachers of Kenya
CITAM	Christ is the Answer Ministries
CM	Community Midwives
CMU	Contraceptive Management Unit
CO	Country Office
COAR	Country Office Annual Reports
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPE	Country Programme Evaluation
CPR	Contraceptive Prevalence Rate
CRC	Convention for the Right of Children
CSOs	Civil Society Organisations
CSW	Commercial Sex Workers
DANIDA	Danish International Development Assistance
DaO	Delivering as One
DASCOS	District AIDS Coordinators
DDO	District Development Officers
DEA	Data Envelopment Analysis
DEDM	Division of Emergency and Disaster Management
DFID	Department for International Development

DHIS	District Health Information System
DHMT	District Health Management Team
DICs	Drop In Centres
DMPA	Depo-Provera
DMU	Decision Making Units
DP	Development Partners
DPHK	Development Partners for Health in Kenya
DPHN	District Public Health Nurse
DRF	Development Results Framework
EAC	East Africa Community
ENC	Emergency Newborn Care
EOC	Emergency Obstetric Care
ERS	Economic Recovery Strategy
FACE	Fund Authorization and Certificate of Expenditure
FANC	Focused Ante-Natal care
FBOs	Faith based Organisations
FGM	Female Genital Mutilation
FP	Family Planning
FSWs	Female Sex Workers
GAVI	Global Alliance Vaccines and Immunisation
GBV	Gender Based Violence
GBV-IMS	Gender Based Violence – Information Monitoring System
GDP	Gross Domestic Product
GE	Gender Equality
GER	Gross Enrolment Rate
GEWE	Gender Equity and Women Empowerment
GIZ	German Development Cooperation
GOK	Government of Kenya
HCT	HIV Counseling and Testing
HMIS	Health Management Information System
HSP	Health Service Provider
ICC	Inter-agency Coordinating Committees
ICPD	International Conference on Population and Development
IDPs	Internally Displaced Persons
IEC	Information, Education and Communication
IGAD	Inter-Governmental Authority on Development
IGAs	Income Generating Activities
ILO	International Labour Organisation
IPs	Implementing Partners

IRC	International Rescue Committee
IUCD	Intra-Uterine Contraceptive Device
IWD	International Women's Day
JPO	Junior Programme Officer
KAG	Kenya Assemblies of God
KAIS	Kenya AIDS Indicator Survey
KANU	Kenya African National Union
KDHS	Kenya Demographic and Health Survey
KEMEP	Kenya Media Network on Population and Development
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KEWOPA	Kenya Women Parliamentarians Association
KfW	German Development Bank
KIE	Kenya Institute of Education
KJAS	Kenya Joint Assistance Strategy
KMTC	Kenya Medical Training College
KNBS	Kenya National Bureau of Statistics
KPHC	Kenya Population and Housing Census
LAPMS	Long Acting and Permanent Methods
M&E	Monitoring and Evaluation
MARPS	Most At Risk Populations
MDG	Millennium Development Goals
MED	Monitoring and Evaluation Department
MHTF	Maternal Health Trust Fund
MIP	Malaria In Pregnancy
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Rate
MHC	Model Health Centre
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPAN	Multilateral Organisation Performance Assessment Network
MOPHS	Ministry of Public Health and Sanitation
MOYA	Ministry of Youth Affairs
MSH	Management Science for Health
MSK	Marie Stopes Kenya
MTP	Medium Term Plan
MTR	Mid-Term Review
MUMCOP	Mumias Muslims Community Programme
MYWO	Maendeleo Ya Wanawake Organisation

NACC	National AIDS Control Council,
NARA	National Accord and Reconciliation Agreement
NARC	National Alliance of Rainbow Coalition
NASCOP	National AIDS Control Programme
NCGD	National Commission on Gender and Development
NCPD	National Council for Population and Development
NEPA	New Partnership for Africa Development
NER	Net Enrolment Rate
NEX	Audit of Funds Implemented by Partners
NGEC	National Gender and Equality Commission
NGO	Non-Governmental Organisation
NHSSP	National Health Sector Strategic Plan
NIMES	National Information Monitoring and Evaluation Systems
OBA	Output Based Approach in AID
ODM	Orange Democratic Movement
OJT	On Job Training
PAK	Population Association of Kenya
PCEA	Presbyterian Church of East Africa
PCM	Programme Cycle Management
PD	Population and Development
PEP	Post-Exposure Prophylaxis
PEV	Post-Election Violence
PHE	Population, Health and Environment
PMTCT	Prevention of Mother To Child Transmission
PNU	Party of National Unity
PRC	Post-Rape Care
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
SBA	Skilled Birth Attendance
SBAA	Standard Basic Assistance Agreement
SDA	Seventh Day Adventist
SGBV	Sexual Gender Based Violence
SIDA	Swedish International Development Agency
SMS	Short Message Service
SOPs	Standard Operating Procedures
SP	Strategic Plan
SPR	Standard Progress Report
SRH	Sexual Reproductive Health

SUPKEM	Supreme Council of Kenya Muslims
SWAp	Sector Wide Approach
SWG	Sector Working Groups
TB	Tuberculosis
TFR	Total Fertility Rate
TOWA	Total War against AIDS
TWG	Technical Working Group
UN	United Nations
UNCT	United Nations Country Teams
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UON	University of Nairobi
VAW	Violence Against Women.
VCT	Voluntary Counseling and Testing
WEL	Women Empowerment Link
WHO	World Health Organisation
YEC	Youth Empowerment Centre
YFS	Youth Friendly Service

Table 1: Key Fact Table (KENYA)

Indicator	
Geographical location	East Africa
People	
Population (2009)	38.6 Million
Urban /Rural Population	32% / 68%
Population growth rate (1999-2009)	2.9%
Government	
Type	Democratic Coalition Government
Economy	
GDP per capita 2011 PPP USD	815
GDP growth rate (2011)	4.4
Main economic activity	Agriculture
Social Indicators	
Human development index (2011)	0.509
Unemployment	12.7
Total net enrollment ratio in primary education, both sexes	112.7%
Adult literacy (% aged 15 and above)	89%
Life expectancy and birth, both sexes	58.1
Under-five mortality (per 1,000 live births)	74
Maternal mortality (deaths of women per 100,000 live births)	488
Births attended by skilled health personnel	44%
Adolescent fertility rate (births per 1,000 women aged 15-19)	100.2
Contraceptive prevalence rate	46%
Unmet need for family planning (% of currently married women, 15-49)	25.6%
Age specific fertility rate (15-19) (KDHS 2008-09)	103
Age specific fertility rate (20-24) (KDHS 2008-09)	238
HIV prevalence rate (15-49) (KDHS 2008-09)	6.3%
HIV prevalence rate 15-24 (KAIS 2007)	3.8%
HIV prevalence rate 15-24: Male / Female (KAIS 2007)	1.4% / 5.6%
Proportion ever tested for HIV and received results (15-19) (KAIS 2007)	28.1%
FGM prevalence	27%
GBV prevalence	37%

FOREWORD

This report is an independent country programme evaluation of the UNFPA support to the Government of Kenya for the period 2009 to 2013. The evaluation examines the strategic positioning of UNFPA support as well as its contribution to the results set out in the three areas of focus on Reproductive Health and Rights; Population and Development; and Gender Equality.

An independent evaluation was conducted by an Evaluation Team (ET) comprised of three experts on the three areas of focus of the seventh country programme of UNFPA support in Kenya (2009-2013). The experts were guided by the Handbook of the Evaluation Branch on How to Design and Conduct a Country Programme Evaluation at UNFPA. Consequently, the evaluation was based on:

(i) A comprehensive review of documents covering both the programming and implementation stages;

(ii) A workshop on country programme formulation and evaluation that was conceptualised, organised and facilitated by the country office, with resource persons drawn from the East and Southern Africa Regional Office (ESARO), the Kenya Country Office (KCO) and Monitoring and Evaluation officers from Rwanda and South Africa Country Offices;

(iii) Extensive fieldwork for further data collection and validation of preliminary findings.

The Evaluation Team worked to obtain the perspectives of all key stakeholders and systematically ensured the validity of collected data by means of triangulation techniques. Specific evaluation questions were formulated during the design phase which referred to:

(i) The evaluation criteria of relevance, efficiency, effectiveness and sustainability in the three focus areas for the country programme; and

(ii) Alignment, responsiveness and added value. The evaluation was complemented by a light analysis of the monitoring and evaluation system of the country programme.

The evaluation benefitted immensely from the continuous inputs provided to the Evaluation Team by stakeholders during various meetings as well as the Evaluation Reference Group (ERG), which was comprised of representatives from the External Resources Department (ERD); National Council for Population and Development (NCPD); the Ministry of Health (MoH); the Monitoring and Evaluation Directorate (MED); the Population Studies and Research Institute (PSRI); the Kenya Red Cross Society (KRCS); the Kenya National Bureau of Statistics (KNBS); the Ministry of Gender, Children and Social Development (MoGCSD); and United Nations Population Fund (UNFPA).

The 7th Country Programme Evaluation Report was produced under the stewardship of the Government of Kenya who ably guided the entire evaluation process. Of special recognition is Dr. Boniface K'Oyugi, the former Director-General of the National Council for Population and Development (NCPD), and Mr. Karugu Ngatia, the NCPD Deputy Director, Programme Coordination, Monitoring and Evaluation, who gave critical leadership and contribution throughout the process.

The UNFPA Kenya Country Office under the leadership of Mr. Fidelis Zama Chi (UNFPA Representative), Dr. Alex Ilyin (UNFPA Deputy Representative) and Dr. Benjamin O. Alli (UNFPA Officer In Charge) accorded tireless support and cooperation to the evaluation team throughout the exercise. Additionally, the entire KCO team was at all times readily available to make valuable contributions in the different programme areas to facilitate the successful compilation of this report. A special mention goes to Ms. Zipporah Gathiti (UNFPA Monitoring and Evaluation Specialist) for coordinating the process. The UNFPA Regional Monitoring and Evaluation Advisor for East and Southern Africa Regional Office, Dr. Reginald Chima, provided technical guidance throughout the various phases.

Appreciation goes to the evaluation team that comprised Prof. Joyce Olenja (team leader/Reproductive Health and Rights), Dr. Seth Gor (Population and Development/Monitoring and Evaluation) and Ms. Ruth Okoth-Juma (Gender Equality). The hard work, commitment and unreserved professionalism that the team demonstrated during the production of the 7th Country Programme Evaluation Report is highly commended.

Our sincere gratitudegoes to all the people who took the time to respond to requests from the evaluation team; including government officials, non-governmental organizations, development partners as well as the UN Country Team in Kenya. Last but not least, a wide number of the country programme beneficiaries and members of the communities that the team visited during the course of the evaluation also provided valuable insights. The implementing partners were particularly instrumental in collating information and organizing site visits and meetings with beneficiaries. Their cooperation is highly valued.

It is important that the recommendations made and lessons learnt during the implementation of all projects and programmes, as expressed by this report, are internalized and become the foundation on which the 8th Country Programme is developed. If these valuable insights are put into place, true progress will achieved, which will result in transforming the lives of millions of Kenyans.

Finally, while this extensive report was conducted by an evaluation team comprised of three independent consultants and produced with the support of the Government of Kenya and UNFPA, the views expressed herein are and remain the property of the authors and do not necessarily reflect the views of UNFPA and/or NCPD.

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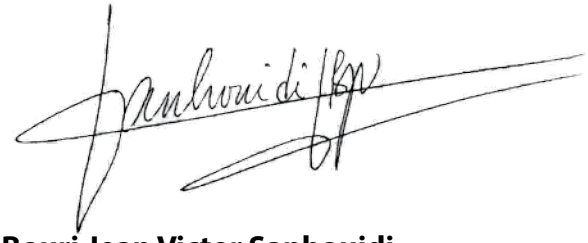

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EXECUTIVE SUMMARY

UNFPAs strategic direction aims at supporting national ownership and leadership, capacity development, advocacy and multi-sectoral partnership development for positioning the International Conference on Population and Development (ICPD) agenda. UNFPAs programming is informed by principles supporting results-based management as well as United Nations reforms, knowledge sharing, and resource mobilisation for population, gender equality and reproductive health programmes. The 7th Country Programme (CP) contributes to three of the six UNDAF outcomes, the MDGs and the ICPD Plan of Action (1994). These are in turn aligned to the First Medium–Term Plan (MTP1) of the Kenya Vision 2030; the long-term blueprint for "transforming Kenya into a newly industrialising, middle-income country providing a high quality of life to all its citizens by 2030 in a clean and secure environment".

The 7th CP focuses on three programme areas: Reproductive Health and Rights; Population and Development; and Gender Equality.

Reproductive Health and Rights outputs respond to two UNDAF outcomes and addresses health priorities outlined in the Kenya Health Policy Framework (1994, 2012-2030), and the National Health Sector Strategic Plan (NHSSP II (2005-2012) and NHSSP III (2012-2016). This component is in line with the National Reproductive Health Policy (2007), the Adolescent Reproductive Health and Development Policy (2003), Plan of Action (2005-2015) and Reproductive Health Commodity Security (2007). The Reproductive Health and Rights component of the CP addresses three outputs and is geared towards supporting national health sector priorities as a way of contributing to the reduction of MDG 4 and 5.

Population and Development (PD) and Gender Equality (GE) components contribute to one UNDAF outcome: "Democratic governance and human rights including gender equality progressively enhanced". The PD component responds to one outcome of the CP: "Population dynamics issues and their inter-linkages with gender equality, sexual and reproductive health and rights, HIV/AIDS and vulnerable groups incorporated in public health policies and programmes, poverty reduction plans and strategies and expenditure frameworks".

The CP outcome of the gender component is gender equality, empowerment of women, and realisation of human rights enhanced.

Purpose of Evaluation

The purpose of this end line evaluation was to assess the 7CP performance, identify factors that facilitated or hindered achievement, and document lessons learned during the programme implementation process. The results of this evaluation are intended to inform the development of UNFPA's 8th Country Programme support to the Government of Kenya. Findings of this evaluation exercise will also provide input to the evaluation of UNDAF-Kenya.

The specific objectives of this evaluation were: The assessment of the 7CP's performance at the various levels of results chain (activities, CP outputs, CP outcomes, UNDAF outcomes, UNFPA SP outcomes and MTP outcomes; the extent to which the implementation framework (partnership strategy; execution/ implementation arrangements; human resources; resource mobilisation; cash transfer modalities; and monitoring and evaluation) enabled or hindered achievement of the results chain; the extent to which the programme is aligned to the Government priorities, is harmonised with MDGs and is supportive of new Aid modalities.

Methodology

Across the programme areas the evaluation applied the following criteria: Relevance, effectiveness, efficiency, and sustainability. At the strategic level the evaluation

focused on corporate and systemic positioning, and the added value of UNFPA. The sampling of respondents was purposive and comprised of implementing partners and officials from UNFPA, UN agencies, and other development partners. The aim was to select implementing partners at national level as well as the focal districts. These included persons from government line ministries, implementing partners, NGOs, FBOs, CSOs and programme beneficiaries. Methods of data collection included document review, key informant interviews, in-depth interviews, focus group discussions (FGDs), narratives and observations. The evaluation team employed the following techniques of data analysis and validation: Content analysis for FGDs and key informant interviews; contribution analysis with IPs, service providers and beneficiaries, trend analysis where feasible for quantitative indicators, ratio analysis, data envelopment analysis and overall triangulation.

Summary of Findings and Conclusions

Strategic Level

At the strategic level UNFPA focused on key areas that were also of priority to the Government and which addressed health priorities outlined in the Kenya Health Policy Framework (1994, 2012-2030). UNFPA was reported to work through the Government by aligning its programme support within the established policy framework and the national execution plan of the Kenya Government. The interventions were deemed relevant to a wide range of stakeholders including the government, non-governmental actors and beneficiaries. Other UN agencies, development partners and the government were clear that RH is the natural niche that UNFPA should re-affirm. Within the joint programmes there was a clear division of labour with each of the UN agencies contributing in line with their core mandate as an agency and this was reported to work well. UNFPA was reported to score well in its partnership efforts, such as contributing to policy dialogue at country level, as assessed, for example, in the 2010 Multilateral Organisations Performance Assessment Network (MOPAN) review. UNFPA was also recognised for contributing to United Nations reform efforts at the global level in terms of chairing committees and task-teams, and at regional level in terms of leading strategic exercises in areas such as youth and maternal health.

Overall the 7th CP operated at both the national and decentralized levels working through government and other implementing partners. At both levels UNFPA's contribution was highly valued. In the 7th CP, UNFPA supported national programmes as well as programme activities in four districts, down from nine districts in the 6th CP. Whereas the choice of the four districts may have been based on health indicators and remoteness for Migori, Naivasha and Kilifi and a poor urban environment for Nairobi West, the geographic spread of these districts was found to partly hinder effective monitoring and supervision of activities. Under the new UNFPA strategic dispensation and devolution of service delivery in Kenya, UNFPA now has the opportunity to redefine its geographic spread. It is recommended that focus be trained on fewer outcomes in selected districts/counties, in line with revision of the results frameworks within the new Strategic Plan based on the need to; consolidate by prioritizing; avoid doing everything everywhere, avoid 'silo' thinking and improve measurability.

Relevance and Effectiveness

The 7th CP was found to be well aligned to key national policy frameworks, UNFPA polices and global priorities in terms of addressing reproductive health and rights, population and development, and gender equality in addition to addressing the needs of vulnerable populations. The overall contribution of the 7th CP was evident in UNFPA's support for policy development and review, capacity building through training at various levels and infrastructure development within the three components. Programme interventions were deemed relevant to a wide range of stakeholders including the government, non-governmental actors and private citizens. However, operational constraints such as the incessant division of existing districts into smaller units and the impending devolution were expected to create challenges that would need to be taken into consideration in planning for the 8th CP.

The planned interventions for the PD component of the 7th CP were found to be relevant in addition to meeting the needs, policies and priorities of a wide range of stakeholders and target groups. Relevance was further evidenced by complementarity between UNFPA and other UN agencies through the existence of joint programming especially on M&E and in active

participation in the Development Partners for Health in Kenya (DPHK.)

At the citizen's level, relevance of UNFPA support manifested itself through technical assistance and capacity building provided by UNFPA, which contributed in part to such positive outcomes as reduced gender disparities in school enrolment rates and increased transition rates. Awareness created through support for integrating Population, Health and Environment (PHE) variables in planning resulted in part to sustained efforts by the Government to integrate principles of sustainable development into the country's policies and programmes with a view to reversing the loss of environmental resources with the attendant direct benefits of increased forest cover.

In the framework of national/sub-national needs, the progress attained in the focal districts suggests satisfaction of an important unmet need in district planning units in terms of data capture and maintenance of relevant databases. This support extended to tracking of MDGs at district level. Effectiveness of programme interventions in PD also manifested itself in the adoption of the national population policy, the progressive integration of emerging population issues into successive annual progress reports of the Vision 2030 and in the general entrenchment of population and environmental issues into the political discourse in the country.

Programme support also helped make reporting strong and consistent thereby leading to enhanced monitoring and reporting of programme performance and MDG target achievements. The programme also provided support to PD through the national statistical system either directly or indirectly. This support helped develop unique and critical skills and capacities in addition to strengthening data collection and analysis functions, thereby improving greatly the quality of data and by extension, the planning process in the country. Close engagement with the Kenya Women Parliamentarians Association (KEWOPA) and the Kenya Media Network on Population and Development (KEMEP) also acted to strengthen advocacy campaigns and awareness creation, both of which served to drive policy dialogue on PD issues at all levels. On the flip side, low levels of awareness still pervade planning at all levels with regard to integration of PHE variables while efforts at strengthening the planning units continue to be hampered by resource constraints.

The Reproductive Health programme component focused on three programme outputs which aimed at increasing availability of maternal health services including prevention and management of obstetric fistula, instituting gender sensitive and culturally sensitive behaviour change interventions for RH including FP and FGM; and increasing availability of high quality services to prevent HIV and STI infections. These interventions were skewed towards women, young people and other vulnerable groups.

The initiatives around setting of model health centres, training of CMs and establishment of youth friendly centres were hailed as bearing the potential for improving access to quality care. However the overall effectiveness of model health centres and youth centres was less evident due to delayed refurbishing/ renovation and equipping of these facilities as a result of cumbersome government procurement procedures; a situation that was often out of the control of UNFPA. The initiative of model health centres was not initially in CPD and was borne in 2010 with much of the work being done in 2011. Much of the equipment was delivered in 2012, close to the final year of the programme, 2013. This made it difficult to assess with certainty the contribution of the model health centres. However with the anticipated extension of the programme to 2014, it is likely that improvements in service utilisation will be registered.

Similarly, the training of community midwives was below the target at 143 out of 270. The training of CMs was conducted by the MOPHS in the model health centres while follow up was conducted by DHMT to ensure linkages, support supervision and referral. This role was often a challenge that was compounded by the observation that CMs did not keep records of their deliveries, which made it difficult to assess their contribution to maternal health. Where records were kept, a rising trend in the use of skilled attendance was observed, as was the case with Riruta Health Centre in Nairobi West district.

Training of surgeons for fistula repair and the support accorded to health facilities for repair services worked well as evidenced by the positive testimonies of OF

survivors. During implementation it became clear that investment in fistula repair at camps was too expensive and unsustainable as the surgeons had to be paid fees for their time. Recognising the need to address sustainability, and in consultation with MOH; preference was placed on the integration of OF in regular health facility surgery as a way of transitioning from the OF camps.

The focus on adolescents and youth as vulnerable groups was another important aspect of the 7th CP. The programme supported two different strands of service delivery; to support entrepreneurship and life skills building on one hand and to support RH service delivery on the other. It is suggested that this approach be re-examined to increase impact. However, the use of comprehensive RH drop-in centres, other HCT initiatives such as moonlighting, outreaches and the peer approach especially in reaching vulnerable groups such as MARPs greatly increased access to SRH/HIV services.

Besides service delivery, the RH component also focused on behaviour change activities such as promotion of good practices for maternal health including family planning and the prevention of female genital mutilation/cutting. These activities contributed, in various ways and at various levels, to the enactment of bills such as the FGM Act 2011, and to the sensitisation and mobilisation of women to access services for fistula repair; often with the outcome of demand for services outstripping supply.

UNFPA also continued to support gender equality. The achievement of its outputs in the 7th CP ensured that gender equality issues remained relevant. The activities under the 7th CP were adequately designed to achieve the expected CPAP results. The implementation rate of the GE outputs was on course and in some cases, surpassed targets as defined at baseline. At the policy level, engagement of male members of Parliament drew immense support to the gender bills, especially during the enactment of the Prohibition of FGM Act, 2011. Working within the parliamentary calendar and targeting parliamentarians proved to be a key strategy that was both cost effective and efficient. This was considered critical given the need for continuous lobbying and advocacy on gender bills, policies and resources to ensure their full implementation.

Efficiency

Efficiency with which resources were converted into output was determined by both internal and external factors. On average, efficiency of disbursements was found to be acceptable and budgetary deviations from planned expenditure fell within the acceptable statistical boundaries suggesting a strong target setting system in the Kenya Country office. Whereas operational inefficiency levels were at times found to be high due to internally generated challenges such as poor reporting, weak indicator design processes and inability to meet some set targets, a number of those challenges were also caused by bottlenecks outside the sphere of control of UNFPA such as capacity issues in government or partners and challenges/delays in procurement that was government controlled. Much however remains to be done to increase efficiency of resource use and implementation of activities.

Sustainability

The consultative and participatory approach to programme design and implementation adopted by KCO helped secure ownership by IPs in the programme thereby enhancing programme sustainability. Support towards capacity building within PD and in particular the investment in knowledge generation institutions such as PSRI ensured sustained manpower development to manage population and development programmes in the country.

In RH, the embedment of programmes within the relevant ministries of health and the use of MOH personnel to cascade capacity building through training was sufficient evidence towards addressing sustainability. The discussions around staffing and support for other services such as human resource, though slow were also indicative of sustainability. Besides, mainstreaming of obstetric fistula repair in regular health facility surgery, though not as frequent, was expected to be aligned with other health facility services over time.

The Gender Equality component focused on utilising existing structures that communities can relate to, to enable effective anchoring of transformative change in gender relations. For instance, through UNFPA support and the existing Government structures, collaborating IPs were able to form, coordinate, facilitate and implement

community level interventions that contributed to the success of the GE programme. Coordination by the Ministry of Gender, Children and Social Development and the National Gender and Equality Commission offered a viable structure for sustaining actions around this component.

Transversal Aspects – Monitoring and Evaluation

The 7th Country Programme successfully supported a number of M&E activities over the programme cycle. However, the M&E function exhibited inherent systemic challenges which acted to compromise effectiveness. Effective monitoring was hampered by weak formulation of indicators and outputs which in turn was compounded by an existing mismatch between indicators, outputs and outcomes; leading to activity level reporting by IPs. Monitoring and follow-up on budget expenditure compliance and appropriate usage of the financial control tool was found to be insufficient as was the monitoring and enforcement of compliance to reporting requirements. In addition, inadequate monitoring of data collection, analysis and management was deemed to have led to constrained flow of information which in turn impacted adversely on data management. Evidence suggested further that management of risks at the CO level was less than adequate due to limited monitoring of risks and assumptions. Besides, support to IPs was found to be focused exclusively on monitoring and much less on evaluation.

Overall the programme performed well within the challenges that were often out of its control. There were promising practices and lessons learnt for the 8th CP mainly working through the government structures and focusing on innovative initiatives such as support towards OF repair, creation of DICs and provision of integrated services, rehabilitation of FSWs through loans and IGAs as well as return to school for young girls; training of community midwives in RH and the use of community structures and relying on male parliamentarians to lobby for legislation for the abandonment of FGM were some of the highlights of the program. Capacity building on PD issues and current investment in advocacy also played a key role in revitalising family planning.

Recommendations

Strategic Level

- With the shift towards "Delivering as One", UNFPA will need to consolidate its position within the UN system by establishing and sustaining a firm niche in reproductive health, population and development, and gender equality.

- As part of upstream interventions, institutional support and capacity building of pre-service training institutions initiated in the 7th CP should be scaled-up in the 8th CP as an assurance of sustainability in RH, PD and gender training and skills development for service delivery.

- Under the new UNFPA strategic dispensation and the devolution of service delivery in Kenya, UNFPA has the opportunity to redefine its focal areas. UNFPA should assume a more cohesive and holistic approach in programming by concentrating on key programme outputs/activities that are likely to make a difference and demonstrate impact. The selection of the geographical areas needs to be re-defined scientifically for effectiveness and efficiency in relation to the new governance structures as well as for easier monitoring and evaluation of programmes.

- With a draft communication strategy in place and a communication officer at the KCO it is imperative that documentation and sharing of best practices with other development partners and stakeholders be up-scaled as a way of enhancing visibility.

Programmatic Level

Reproductive Health

- The focus on MDG 5 should also address availability of RH and family planning commodities and equipment in particular LAPMs since a critical constraint in providing FP services was found to be lack of access to commodities. This should be accompanied by an aggressive demand creation programme that builds on existing community strategies and structures.

- The focus on youth remains critical but UNFPA should consider supporting youth within the model of youth friendly services where reproductive health is primary and where UNFPA has a comparative advantage

- Considering UNFPA's comparative advantage in SRH, it is crucial that UNFPA provides technical support to the Ministry of Education (especially KIE) on comprehensive sexuality education in the school curriculum

- UNFPA should scale up its support towards humanitarian response and towards comprehensive RH drop-in centers, other HIV CT initiatives such as moonlighting, outreach and the peer approach in reaching vulnerable groups such as MARPs and SWs; to increase access to SRH/HIV/AIDS services.

Population and Development

- In planning for the 8th CP it would be prudent to emphasise on conducting baseline survey where there is no data and to emphasise data capture by IPs to facilitate realistic target setting and trend analysis at both MTR and CPE. This could be reinforced as part of IPs core deliverables.

- To increase sustainability and demonstrate impact, it is necessary to enhance support to IPs in the knowledge industry and to invest in research, specialised studies and/or region specific surveys so as to add value and increase dissemination/visibility to the work that UNFPA supports.

- To improve overall programme performance of the 8th CP, measures should be urgently put in place to help unearth and resolve the causes of lack of compliance with RBM requirements, especially regarding reporting on results in the 7th CP. Consideration should be given to an urgent review of reporting tools, additional training in RBM and tracking of trainees and their deployment over time.

Gender Equality

- There is need to support development of accurate baselines and collection and analysis of sex and age disaggregated data to establish trends, anchor proper mitigation as well as provide effective and efficient support to interventions.

- There is need to address socio-cultural issues and to advocate for improved infrastructure and adequate resources in line with MDG 5 so as not to lose on the gains already made towards addressing GBV and FGM/C.

- Strengthening of existing and creation of new community structures is critical to act as safety nets for girls who escape FGM. This can be done by reinforcing community based structures such as community networks to prevent and respond to GBV and FGM/C and to facilitate community dialogue.

- The 8th CP should emphasise on up-scaling of GBVIMS in other public hospitals and enhancement of ownership by MOH, MOPHS, KNBS and MOGSD so as to provide information to aid in programme planning and implementation.

Transversal Aspects: Monitoring and Evaluation

- The KCO needs to identify, formalise, document and assess the risks and assumptions affecting the CP as part of risk management. It also needs to work out mitigating factors so that there is some level of anticipation and preparedness to inform realistic target setting and to support a RBM culture

- In recognition of the importance of M&E it would be prudent to strengthen the KCO M&E function/desk to manage data capture and to oversee production of reports that inform not only programming within UNFPA but also other stakeholders. In this light the roles and responsibilities of the NPPPs positioned in line ministries or IPs should be clarified so that they are able to effectively monitor and document programme activities.

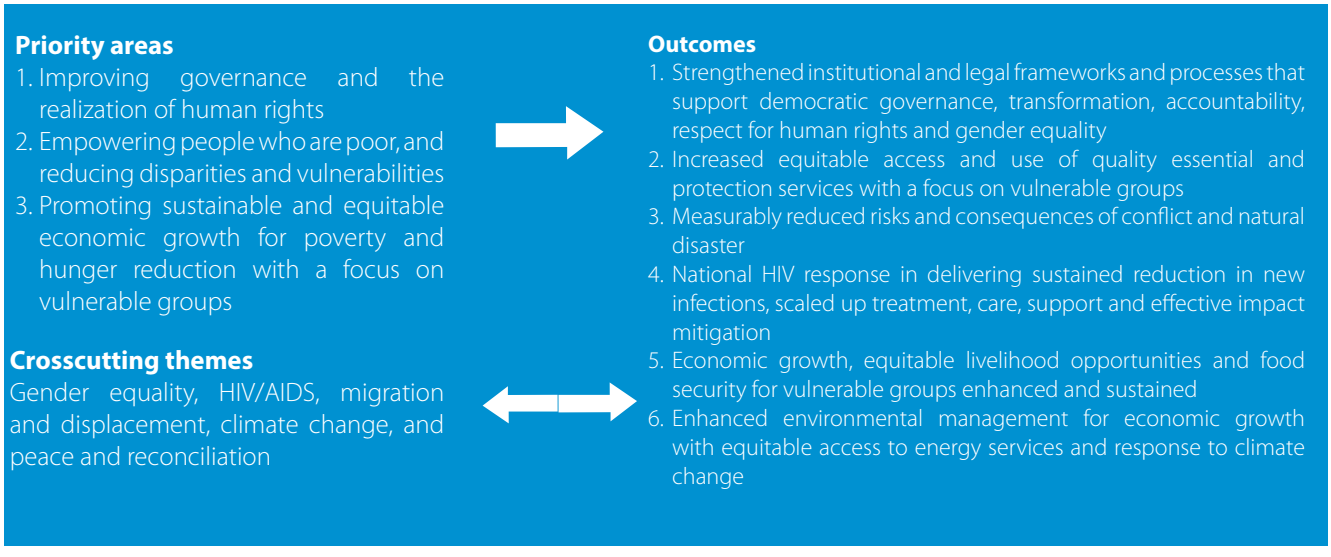
- It is important that the M&E framework for the 8th CP be developed during the design stage of the programme and that the framework be structured to feed adequately into NIMES.

- To strengthen and place the M&E system on a firmer evidence-based footing, there is need to carry out a comprehensive evaluation of the KCO M&E system.

Chapter ONE
INTRODUCTION

The 7th Country Programme (CP) built on some of the strengths of the 6th Country Programme with regard to co-ordination, application of culturally sensitive approaches, advocacyfor increased budgetary allocation to reproductive health and the ability to collaborate with other development partners. The 7thCP support to the Government of Kenya (UNFPA 2008[1])responded to national policies and priorities as articulated in the First Medium Term Plan (MTP I) (2008-2012) and the United Nations Development Assistance Framework (UNDAF) (2009-2013)for Kenya. The MTP I (2008-12) constituted the first phase in the implementation of Kenya Vision 2030, whose aim isto transform Kenya into a modern, globally competitive, middle income country, offering a high quality of life for all citizens by the year 2030.UNDAF-Kenya provides the framework for UN coordination and assistance in achieving these goals. UNDAF-Kenya is grounded on three priority areas, six outcomes and other crosscutting themes as shown in the figure below.

Figure 1: Kenya UNDAF (2009 – 2013) Priority Areas and Outcomes



1.1 Purpose and Objectives of the Country Programme Evaluation (CPE)

The purpose of the end line evaluation was to assess the 7th Country Programme performance, to identify factors that facilitated or hindered achievement, and to document lessons learnt during the programme implementation process. The results of this evaluation are expected to inform the development of the 8th Country Programme of UNFPA support to the Government of Kenya as well as to provide input to the evaluation of the UNDAF-Kenya.

The specific objectives of this evaluation were to:

- Assessthe GOK/UNFPA 7CP's performance at various levels of results chain (activities, CP outputs, CP outcomes, UNDAF outcomes, UNFPA SP outcomes, MTP outcomes).
- Assess the extent to which the implementation framework (Partnership strategy; execution/ implementation arrangements; human resources; resource mobilization; cash transfer modalities; and

1 UNFPA 2008: UNFPA, Final Country Programme Document for Kenya: DP/FPA/CPD/KEN/7. 6th October 2008.

monitoring and evaluation) enabled or hindered achievement of the results chain i.e. what worked well and what did not work well.

- Assessthe extent to which the programme is aligned to Government priorities, is harmonised with MDGs and is supportive of new Aid modalities.
- Identify success stories and documentlessons learnt in programme implementation, management and coordination.

The evaluation appliedthe following criteria:

Relevance of the programme to Kenya's national development priorities, to the achievement of UNDAF priorities and to solving the identified problems and needs of beneficiaries;

Effectiveness of the programme in terms of meeting the planned objectives, the engagement of the Country Office in United Nations (UN) reform processes and in upstream and downstream work, the joint programme modality contributing to achievement of UNFPA's Strategic Plan (SP) results and the coordination mechanisms contributing to the achievement of the expected results;

Efficiency of the programme in terms of results versus inputs, gender mainstreaming being addressed in the design and implementation of the 7thCP, the efficiency of the implementation strategies as well as the process and systems used, including the application of results based management in achieving CP results;

Contribution of the programme to the intended outcomes in terms of changes in the lives of beneficiaries;

Sustainability of the programme and capacity of the implementing partners and Government to scale up programme activities and to maintain positive changes brought about by interventions.

In addition, data strategic alignment of UNFPA was collected, covering corporate and systemic dimensions as well as the level of responsiveness and added value in terms of UNFPA's comparative advantage.

1.2 Scope of the Evaluation

The scope of evaluation spanned the overall UNFPA support to the Government of Kenya as envisaged in the 7th Country Programme document (2009-2013) and the 7th Country Programme Action Plan (2009-2013). The evaluation coveredthe financial support provided to the Kenyan Government through regular and other resources. Specifically, the evaluation focused on programme aspects, geographical regions and sources of finance as itemised hereafter.

Programme: The evaluation focused on all the programme aspects contained in the approved 7th Country Programme Document (CPD), and elaborated in the Country Programme Action Plan (CPAP).

Geographical regions:The evaluation covered the programme focus districts of Nairobi West, Kilifi, Naivasha and Migori. In addition, the evaluation considered all other programme interventions that are broad based with a national perspective, which included but was not limited to policies, strategies, laws and legislation. Other targeted interventions inOF and FGM/C were also evaluated.

Funding source: The evaluation focused on interventions supported by regular (core) resources from UNFPA as well as trust funds from donors such as DFID, SIDA and Norway among others.

1.3 Methodology and Process

The CPE evaluation methodology was participatory, collecting data that was predominantly qualitative from project managers and implementers, service providers at health facilities and beneficiaries. Proceedings of astakeholder workshop where IPs made presentations on activities and achievements to date provided the initial briefing on the 7th Country Programme. Quantitative data such as service statistics at health facilities, financial data as well as data from HMIS was also collected as appropriate. Document review as a source of data was undertaken on a continuous basis.

1.3.1 Methodology

Evaluation Criteria: The evaluation criteria as provided by UNFPA in the Terms of Reference and subsequent evaluation questions were developed for each of the focal areas of evaluation. For each of the programmatic

levels, the four aspects of the evaluation criteria (relevance, effectiveness, efficiency and sustainability) were applied.Atthestrategic level the evaluation focused on corporate and systemic positioning and added value of UNFPA.

Methods for Data Collection and Analysis: The scheduled CPE had a short data collection and data analysis period. In view of this, data collection was limited to document review, individual interviews, focus group discussions, and case studies or narratives as described below:

Document Reviewwas based on arange of relevant documents including programming documents, previous evaluation reports, progress and monitoring reports and all other documentation provided by UNFPA KCO and implementing partners. Other key data sources included KDHS, Census data,AOPs,Kenya Service Provision Assessment Survey (KSPA2009/10), and Kenya AIDS Indicator Survey (KAIS 2007).

Key Informant Interviews were conducted withprogramme managers in the KCO, other relevant UN agencies, development partners, and policy makers in the relevant ministries and departments. Information collected from key informants was triangulated with data from document review in assessing programme implementation, documentation and dissemination strategies.

In-depth Interviewswere conducted with selected service providers at focal health facilities and heads of implementing organisations including NGOs, CBOs and FBOs.

Focus Groups Discussionswere used for eliciting information on access to services and utilisation experiences including challenges facing community members/beneficiaries of the programmes as well as the programme managers. Stakeholderswere categorised into fairly homogenous groups to facilitate this interaction, notablybeneficiaries of the CP and members of the DHMTs.

Observation is a cross-cutting methodology that was applied appropriately to ongoing programmeactivities at the sites

Narrativeswere employed to allow respondents describe their experiences in a given context; in this case either as change agents or persons who have benefited from or contributed to the programme in a significant way. In this evaluation narratives were obtained fromobstetric fistula and SGBV survivors.

Selection of the Sample of Stakeholders: Sampling of respondents was purposive and comprised of implementing partners and relevant staff from UNFPA. This included persons from central and local government, UN agencies, UNFPA programme officers, implementing partners, NGOs, FBOs, CSOs and programme beneficiaries, both from the national andthe district levels.The list of participants is in Appendix 1.

Methods for Data Validation and Analysis:

The evaluation team employed the following techniques of data validation and analysis:

- Content analysis for focus group discussions, indepth interviews and key informant interviews
- Evidence based approaches to assess the evaluative information gathered through the various methods of data collection
- Triangulation
- Trends analysis for quantitative indicators
- Contribution analysis
- Ratio analysis
- Data envelopment analysis

Table 2: CPE Limitation and Mitigation Steps

Limitation	Mitigation
Availability of adequate baseline data	Triangulated the collected data with available data at the health facilities, views from beneficiaries and data from DHIS2
The programme interventions funded by UNFPA were often conducted in collaboration with other agencies and it is not possible to say with certainty that the interventions by UNFPA are solely responsible for specific improvements/outcomes. Hence difficulty of attributing outcomes achieved to inputs by UNFPA and of demonstrating a causal relationship	Implementers were able to apportion UNFPA's contribution within the overall sector or district specific needs and objectives Triangulation of similar opinions about UNFPA's contribution from different respondents/IPs/ beneficiaries
Timeframe for data collection was limited	Follow-up calls were made to implementing partners in the field during the data analysis and report writing stage to fill any missing data gap
Unavailability of the actual field staff with authority over actual programme implementation	Representatives interviewed plus follow-up calls to the actual programme managers
Delayed or missed appointments in Nairobi Delayed data that was being collated from the districts Prolonged data collection and drafting of report	Repeat appointments Repeat appeals to the MOHs to deliver data Review documents

1.3.2 The Evaluation Process

The evaluation process hadfive phases:

The Preparatory Phase involveddrafting ofthe terms of reference by KCO, followed by selection of the evaluation team and constituting of an evaluation reference group.

The Design Phase entailedstructuring the evaluation, including briefing the evaluation team and preparation of the design report by the evaluation team in consultation with the evaluation manager and other stakeholders.

The Field Phase consisted offield trips to project sites in Naivasha, Nairobi West, Migori, Kilifi and Mumias.

The Reporting Phase entailed drafting of the evaluation report.

The Dissemination and Follow-Up Phase will be at the point wherethe main recommendations of the final evaluation report will be circulated to the relevantunits (country and regional offices, and divisions at UNFPA headquarters) who will in turn be invited to submit a response. The responses will then be consolidated into a final management response document.

Chapter TWO
COUNTRY CONTEXT

2.1 Development Challenges and National Strategies

Kenya is located on the eastern part of the African continent. The country size is approximately 571,466 square km with over 80 percent of its land being arid and semi-arid (KNBS, 2010). The Kenyan economy grew in the year 2006 by 6.3 percent, but due to political instability experienced in 2007/8 GDP growth rate declined to 1.5 percent in 2008 before picking up again to 2.7, 5.8 and 4.4 percent in 2009, 2010 and 2011 respectively. In 2012 GDP was projected to grow at 4.3percent. The national GDP per capita for Kenya also grew, rising from USD 775 in 2009 to USD 815 in 2011 (World Bank, 2012).

Until 2010 Kenya was divided into eight administrative provinces, 210 parliamentary constituencies, and 158 districts. With the enactment of the Constitution of Kenya 2010, the country's governance structure has changed significantly. The country has now been sub-divided into 47 devolved units of governance called counties (GOK, 2010).

2.2 Population Trends and Development in Kenya

In the 2009 Census, the total population of Kenya stood at 38.6 million with a majority of these (68%) living in rural areas (KNBS, 2010). Young people aged 15-24 comprised almost 21 percent of this total (KNBS, 2010). The annual population growth rate declined from 3.4 to 2.9 percent over the years 1979-1989 and 1989-1999 respectively. The current population growth rate is 2.9 percent. This drop is attributed to persistent decline in fertility rates in the recent decades. The country experienced a significant decline in total fertility rate (TFR) from 8.1 births per woman in the late 1970s to 4.6 births per woman in 2008-09. The Contraceptive Prevalence Rate (CPR) also increased from 39 percent (KDHS 2003) to 46 percent (KDHS 2008-09).

The decline in fertility levels manifested itself in the age distribution of the country's population, an offshoot of which is the challenge of providing a large number of youth with opportunities for a safe, healthy and economically productive future. In recognition of these challenges, a number of population and family planning policies and programmes were put in place. In 2011, NCPD developed the Population Policy for National Development 2011-2030 together with its action implementation plan to provide the road map for implementation of population policies in Kenya. This policy was adopted.

2.3 The Kenya Health Sector

In 1994 the Government of Kenyan published the Kenya Health Policy Frameworkpaper, which envisioned provision of "quality health care that is acceptable, affordable and accessible to all" by 2010. The policy framework was implemented through two five-year plans. The first National Health Sector Strategic Plan (NHSSP I)covered the period 1999-2004, and the second covered the period 2005-2010. The framework for health policies in the country was set by the Poverty Reduction Strategy Papers (PRSPs) issued in 2001 and 2003 (Economic Recovery Strategy, ERS). The PRSPs were accompanied by the 9th National Development Plan (NDP) of 2002-2008 and the first National Reproductive Health Policy 2007-2011.

The Constitution of Kenya (2010) is explicit about reproductive rights and provides a legal framework for ensuringa comprehensive, rights-based and people driven delivery of health services. This is envisioned in the Kenya Health Policy Framework (2012-2030) whose aim is to support provision of equitable, affordable and quality health and related services at the highest attainable standard to all Kenyans. Kenya Vision 2030 is the country's long-term development strategy for the period 2008-2030.Population dynamics, reproductive health, HIV/AIDS, youth and gender equality were comprehensively incorporated in the First Medium-Term Plan (MTP I, 2008-2012) of this vision.

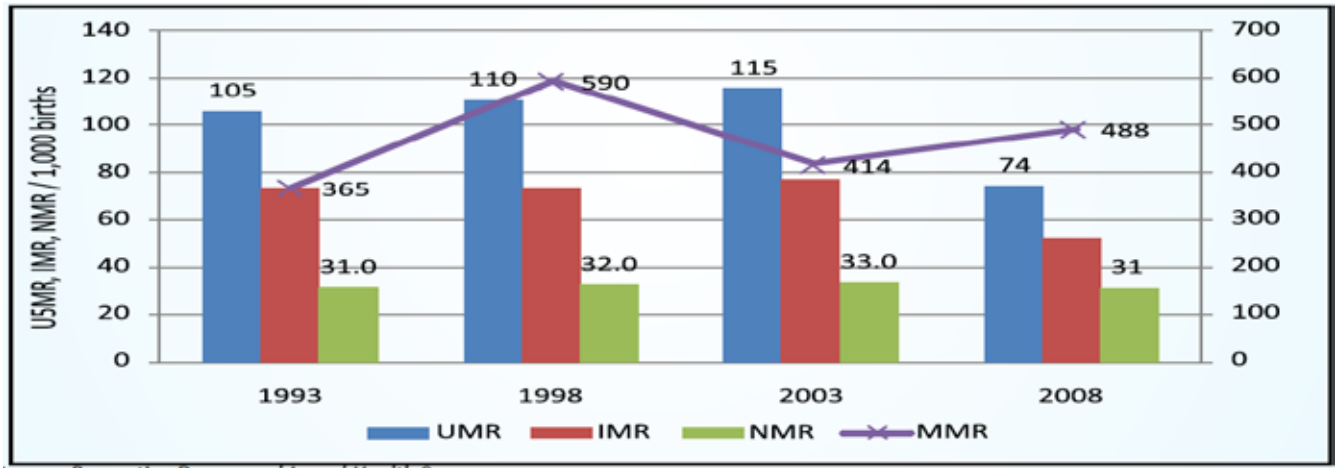
The National Health Sector Strategic Plan II (NHSSP II) (2005-2010) provided the framework for health service delivery as well as health sector reforms in Kenya. NHSSP II aimed at reducing inequalities in health as well as reversing the downward trend in outcome and impact indicators of health through the introduction of Kenya Essential Package for Health (KEPH) that addressed individual health needs through six stages of the human life cycle: Pregnancy, delivery and the newborn; early childhood; late childhood; adolescence, adulthood and the elderly. KEPH services are delivered through six defined levels of health care. These are community level; dispensaries and clinics; health centres, maternity and nursing homes; secondary hospitals and tertiary hospitals.

Public health expenditure patterns in Kenya show that households, at 36 percent were the major financing source of contributors of health fund followed by donors (31%) and the government (29%). Most of such funds were consumed by curative services (69%), followed by preventive and public health programmes (11.8%) and 14.5 percent for public health administration. HIV/AIDS and RH consumed 38 percent of the total resources (MOH, 2008). The HIV/AIDS epidemic in Kenya had a negative impact on all development sectors. Consequently, HIV/AIDS, maternal and child health became the government's key priority areas.

2.4 Status of Millennium Development Goals in Kenya

The Millennium Development Goal 2009 Status report indicates progress towards attainment of some MDGs. In 2009 for instance, gross primary school enrolment rate stood at 110 percentcompared to 73.7 percent in 2002.Similarly, in 2008-09, the infant mortality rate was 52 deaths per 1,000 live births down from 77 deaths per 1,000 live births in 2003 while the under-five mortality rate stood at 74 deaths per 1,000 live births in 2008/09 down from 115 in 2003. Currently prenatalmortality rate stands at 37 per 1,000 pregnancies reaching seven months of gestation. In addition, immunisation coverage increased from 57 percent in 2003 to 72 percent in 2007 and 77 percent in 2008/09 as shown in Figure 2.

Figure 2: Trends in Health Sector Indicators



Source: Health Policy Framework (2012-2030)

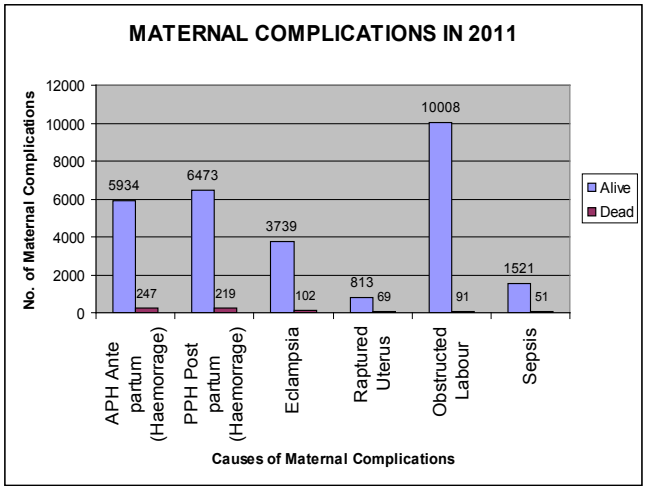
2.5 Reproductive Health

Maternal mortality levels remained high at 488 deaths per 100,000 live births (KDHS 2008-09). WHO (2006) estimates identified causes of maternal deaths in sub-Saharan Africa as; haemorrhage (45%); hypertensive disorders (12%); complications of abortions (5%); sepsis/infections (13%), obstructed labour (6%), and other direct causes (10%). In Kenya the pattern is similar with haemorrhage accounting for 60 percent; eclampsia (13%), complications of abortions (5%); sepsis/infections (7%), obstructed labour (12%) and ruptured uterus (9%).

Although the number of pregnant women attending ANC increased from 88 percent (KDHS 2003) to 91.5 percent (KDHS 2008/09), deliveries by skilled attendanceremained relatively low at 42 percent. Only 47 percentof pregnant women attendedantenatal care

(ANC) at least four times. ANC services were generally available in 74 percent of facilities, PNC (59%) and TT vaccine (69%). Only 56 percent of the facilities were able to provide all the three services (ANC, PNC and TT). HMIS data for Kenya shows that in the year 2011, there were a total of 779 maternal deaths in Kenya, a majority (60%) of them caused by haemorrhage. There were also a total of 28,483 maternal related complications with majority being due to haemorrhage (44%), followed by obstructed labour (35%) (Figure 3). This is in spite of the low reporting rates nationally.

Figure 3: Maternal Health Complications and Deaths, Year 2011



Source: HMIS data 2011

The HIV/AIDS epidemic in Kenya had a negative impact on all sectors thereby eroding all the gains made on MDG-related health indicators. According to the 2007 Kenya HIV/AIDS indicator survey, 7.1 percent of the Kenyan population aged 15-64 were HIV positive with women (8.4%) more likely to be affected than males (5.4%). There were distinctive regional variations in HIV prevalence ranging from 15 percent in Nyanza province to 0.8 percent in North Eastern Province; although 84 percent of the population did not know their HIV status (KAIS, 2007).

2.5.1 Youth and Adolescents

Adolescents and youth constitute a large proportion of the population in the world especially in sub-Saharan Africa. Almost half of the world population consists of young people below 25 years of age (World Bank, 2011). Young people from sub-Saharan Africa are more at risk of experiencing reproductive health problems than youth from around the world due to the social and low economic conditions in the region (Ringheim and Gribble 2010). In Kenya, almost half of all births among adolescents were unintended (unwanted or mistimed) (Ringheim and Gribble 2010).

Addressing adolescent childbearing effectively should, therefore, make a significant contribution to the achievement of MDG 5b (United Nations 2010). Of all the age groups, young people had the highest unmet need for contraception. DHS data indicated that a large proportion (67%) of married adolescents in sub-Saharan Africa wanted to avoid pregnancy for at least two years but were not using any form of contraception (Guttmacher Institute and IPPF 2010).

Over half of all the new HIV infections occurred among young people aged 15-24, with young women being four times more likely to be infected with HIV than young men of the same age group (Ringheim and Gribble 2010). In spite of this, condom use was still very low and testing for HIV was rare (Khan and Vinod 2008).

2.6 Gender Equality

Kenya is a signatory to, and has ratified many international and regional conventions on gender equality and empowerment of women, such as the Convention on the Elimination of all forms of Discrimination against Women, the AU Solemn Declaration on Gender Equality and IGAD Framework for Gender Equality. The achievement of all the MDGs is partly premised on the achievement of gender equality and empowerment of women. This was highlighted in the State of the World Population Report 2005, with MDG 3 specifically focusing on achievement of gender equality. The Government of Kenya developed several mechanisms for achieving gender equality. Consequently, analysis tool for designing interventions are key pillars that form part of the UN mandate of its support for national initiatives in Kenya.

The status of women in the institution of marriage was also significantly boosted. The Constitution of Kenya provides that men and women be entitled to equal

rights in marriage and in the event of a divorce, assures that parental responsibility is shared between parents, whether or not they are married. The right to inherit and own land is also protected (The Constitution of Kenya 2010). The Family Protection Bill 2007, The Equal Opportunities Bill 2007, The Property Rights Bill 2007, The Matrimonial Property Bill 2007 and The Marriage Bill 2007, all collectively referred to as the Family Bills, were all reviewed by the Kenya Law Reform Commission and earmarked for processing within the next five years as per the fifth schedule of the Constitution.

One key indicator of progress in gender equality is education at all levels. In Kenya, girls were more likely than boys to stay in school during the first half of primary school. Data from the latest Kenya Economic Survey reveal that the Gross Enrolment Rate (GER) at primary education level increased from 108.9 percent (118% and 106% for boys and girls respectively) in 2007 to 110.0 percent (112.8% and 107.2% for boys and girls, respectively) in 2009, and dropped slightly to 109.8 percent (109.8% and 109.9% for boys and girls respectively) in 2010.

Based on the Net Enrolment Rate, gender disparity in enrolment improved in favour of girls. The gender parity index at primary level was 0.97 in 2007 and 0.98 in 2009 while in 2010 it stood at 1.02. In the second half of primary school, girls were found to be more likely to leave school as cultural pressures such as early marriage cut short their education. Girls also dropped out of school on account of pregnancies, the burden of household responsibilities and gender violence within communities and school environments (Kenya Economic Survey/MOE 2010). In the political realm, women's representation steadily increased, reflecting a change in perception of women in leadership. The percentage of women MPs increased from 1.1 percent in 1990 to 9.8 percent in 2009 (MOGSD 2010).

The Kenya Vision 2030 strives to mainstream equality in all aspects of the society. In this regard, gender equality was addressed by making fundamental changes in aspects concerning opportunities, employment and vulnerabilities. In the First Medium Term Plan (MTP I) 2008-2012, gender issues were mainstreamed in government policies, plans, budgets and programmes.

2.7 The Role of External Assistance

For the year 2011, approximately USD 643 million from external assistance was provided to the health sector in Kenya. This accounted for about 52 percent of the total health sector resource envelop. The US Government provided almost two-thirds of the total external assistance received byKenya.Other development partners that provided significant support to the health sector in Kenya included over 20 bilateral and multilateral development partners (DPs), almost entirely through projects and programs.

Global Alliance for Vaccines and Immunisation (GAVI), the African Development Bank, the World Bank and DfID, each contributed about five percent of the total support. Much of this support went into service delivery inputs (72%); procurement of drugs and commodities (19%); systems support and strengthening (4%) and infrastructural improvements (4%). However, the new funds were mainly off-budget andtargeted disease-specific interventions especiallyprevention and mitigation of HIV and AIDS. Thus, this support only partially benefited the health system at large (UNFPA 2011)[2].

UNFPA KCO resource mobilisation environment was found to be aligned to the new aid architecture as outlined within the Paris Declaration on Aid Effectiveness, the Accra Roadmap and Busan. The resource mobilisation was found to be in line with the aid effectiveness principals that emphasise the need for country ownership of development, donor alignment and harmonisationbut compliance by partners was generally low.A number of challenges were encountered in resource mobilisation over the programme cycle due to a highly competitive aid environment, the UN reforms and 'Delivering as One' agenda, decrease in funds from traditional donors, the push for accountability and a results/evidence-based development agenda, coupled with commitments of the GOK and DPs towards MDG 5 (a and b).

To mitigate, UNFPA KCO's strategy for resource mobilisation re-focusedon emerging donor countries (BRICS) and private sector entities such asSafaricom

2 UNFPA 2011: Thematic Evaluation of UNFPA's Support in Maternal Health including the Maternal Health Thematic Funds Contribution. Country Cases Study Note: Kenya 2011.

and Nakumatt, in addition to the Government of Kenya, other UN agencies, NGOs and FBOs, the academia, the media and CBOs whose partnership was mainly in leveraging advocacy and communication in addition to acting as enablers for programme intervention. UNFPA KCO also formed partnerships with both traditional and emerging (bilateral and multi-lateral)donors. Table 3 reports the major partners in the programme cycle.

Table 3: Major Donors and Areas of Collaboration/Partnership in the 7thCP

DONORS	AREA OF SUPPORT AND COLLABORATION
Government of Kenya	Main collaborating partner and donor
DFID	Joint Programme on HIV/AIDS
Government of Norway	Gender-Based Violence (GBV) and Junior Programme Officer (JPO)
Danish International Development Agency (DANIDA)	Gender-Based Violence (GBV)
Swedish International Development Agency (SIDA)	Census
United Nations Children's Fund (UNICEF)	Census
UNFPA Maternal Health Trust Fund	Obstetric Fistula
UNFPA Global Programme for Reproductive Health Commodity Security	Reproductive Health
UNFPA Humanitarian Response Fund	Humanitarian Response
UNFPA/UNICEF FGM/C Global Campaign	Abandonment of FGM/C
Government of Netherlands	Junior Professional Officer (JPO)
UN Central Emergency Relief Fund	Humanitarian Response
Packard Foundation	Youth and Family Planning

Chapter THREE

UNFPA STRATEGIC RESPONSE & PROGRAMME

3.1 United Nations and UNFPA Strategic Response

The relationship between the Government of Kenya and the United Nations Population Fund is governed by the Standard Basic Assistance Agreement (SBAA) signed by the Government and the United Nations Development Programme (UNDP) in 1991, which also applies to UNFPA. The basis for the 2009-2013 Country Programme is embedded in the United Nations Assistance Development Framework (UNDAF) that outlines concepts and commitments jointly determined by UN partners in Kenya in close partnership and with full leadership of the Government of Kenya. The UNDAF Kenya aims to contribute to the realization of national priorities, the achievement of human rights and the principles and values embedded in the MDGs as well as providing a common agenda and framework for all development partners, the UN and GOK to work together. The UNDAF articulates the structure of the UN system in Kenya's operations in support of national development priorities over a five-year programme cycle and facilitates a holistic and nationally owned approach to the country's challenge (Kenya UNDAF 2009- 2013).

The overall goal of the new UNFPA Strategic Plan 2012-13 is to achieve universal access to sexual and reproductive health (including family planning), to promote reproductive rights, to reduce maternal mortality, and to accelerate progress on the ICPD agenda and MDG 5 (A and B), in order to empower and improve the lives of underserved populations, especially women and young people (including adolescents). This is enabled by an understanding of population dynamics, human rights and gender equality, and driven by country needs as tailored to the country context.

The UNFPA Strategic Plan (2008-2011) laid emphasis on supporting countries to implement national priorities based on ICPD goals. The strategic plan focused on three areas: 1) Population and Development; 2) Reproductive Health and Rights and 3) Gender Equality. The goals of the plan are anchored on each of the three focus areas which include:

- Systematic use of population dynamics analyses to guide increased investments in gender equality, youth development, reproductive health and HIV/AIDS for improved quality of life and sustainable development and poverty reduction.
- Universal access to reproductive health by 2015 and universal access to comprehensive HIV prevention by 2010 for improved quality of life.
- Advanced gender equality where women and adolescent girls are empowered to exercise their human rights, particularly their reproductive rights, and live free of discrimination and violence.

The plan aimed at promoting national ownership and leadership by programme countries and communities while enhancing national capacity development, advocacy and strengthening of institutional support systems for governmental and civil society organisations. The 2008-2011 Strategic Plan had three interlinked frameworks: 1) the development results framework 2) the management results framework; and 3) the integrated financial resources framework.

The revised UNFPA strategic plan is the guide for organisational programming, management and accountability for the period 2012-2013. In revising the strategic plan, UNFPA adopted a refined strategic focus, which is designed to direct its work largely on sexual and reproductive health and reproductive rights, while facilitating greater progress towards MDG 5 and the ICPD agenda.

The UNFPA Development Results Framework (DRF) (2012-2013) as approved by the UNFPA Executive Board is envisaged in the following seven results areas:

- Population dynamics and its inter-linkages with young people's needs, reproductive health, gender

equality and sustainable development and poverty reduction addressed in national development plans and poverty reduction strategies

- Access to and utilisation of quality maternal and newborn health services increased
- Access and utilisation of quality family planning services for individual and couples increased according to reproductive intentions
- Access and utilisation of quality HIV and STI prevention services increased especially for young people and other key populations at risk
- Gender equality and reproductive rights advanced particularly through laws and policies implementation
- Young people's access to sexual and reproductive health services and sexuality education improved
- Improvements in data availability and analysis result in improved decision-making and policy formulation around population dynamics, sexual and reproductive health, and gender equality

3.2 United Nations and UNFPA Response through the Country Programme

3.2.1 UNFPA 6th Country Programme Strategy

The 6th Country Programme supported national level policy development and programme activities in nine districts geographically spread out in all the eight provinces. This support included strengthening of institutional and technical capacity of implementing partners to provide a range of reproductive health and HIV/AIDS prevention services, including a referral system for emergency obstetric care; reproductive health commodity procurement and security; and capacity development for service providers in behaviour change communication. Achievements included: (a) increased availability and utilisation of comprehensive and basic emergency obstetric care services; (b) integrated basic and youth-friendly adolescent reproductive health services; (c) improved prevention and management of harmful traditional practices and gender-based violence; (d) increased budgetary allocations for family planning; (e) increased capacity for obstetric fistula repair; and (f) increased participation by community midwives in the provision of skilled attendance at deliveries.

UNFPA's goal is to achieve universal access to sexual and reproductive health (including family planning), promote reproductive rights, reduce maternal mortality, and accelerate progress on the ICPD agenda and MDG 5 (A and B), in order to empower and improve the lives of underserved populations, especially women and young people (including adolescents), enabled by an understanding of population dynamics, human rights and gender equality, and driven by country needs and tailored to country contexts.

In the area of population and development, the programme focused on: (a) building the institutional and technical capacity of coordinating and implementing partners in programme management; (b) integrating population and environmental issues into ministerial policies and programmes; and (c) developing an integrated multi-sectoral information system to track progress made in achieving the Millennium Development Goals.

In the area of gender equality, the programme promoted the integration of gender issues into policies and programmes by national and local institutions, and increased the availability of gender-sensitive data. Other achievements included the development of a national gender and development policy and action plan; national guidelines for treating victims of rape and other forms of sexual violence; and a situation analysis on female genital mutilation/cutting.

The strengths of the 6th Country Programme included: (a) the use of coordination mechanisms; (b) the application of a culturally sensitive approach to programming; (c) the ability to advocate for increased government resources to procure reproductive health commodities; and (d) the ability to ensure the prioritisation of reproductive health in the health sector-wide approach programme.

Major challenges included: (a) delays in the flow of funds from the Treasury to government agencies due to internal procedures and the differing fiscal years of UNFPA and the Government; (b) inadequate technical

Table 4: Country Programme Outputs, Outcomes and the UNDAF Outcomes

Component	Country Programme Output	Country Programme Outcome	UNDAF Outcomes
Reproductive Health and 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.	Increased utilisation 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 theprotection of human rights.	Increased equitable access to and use of high-quality, essential social and protection services, with a focus on vulnerable groups Evidence-informed and harmonised national HIV response to reduce new infections; scale up treatment, care and support; and mitigate the impact of the disease.
Population and Development	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.	Population dynamics issues and their inter-linkages 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.	Democratic governance and human rights including the progressive enhancement of gender equality.
Gender Equality	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	Gender equality, the empowerment of women and realisation of human rights enhanced	Democratic governance and human rights including the progressive enhancement of gender equality.

and managerial capacity; (c) limited utilisation of long-term and permanent methods of contraception; and (d) a lack of preparedness for the post-election political and humanitarian crises.

Lessons learned included: (a) results were attained more quickly with effective programme coordination; (b) networking was enhanced by joint monitoring visits and regular information-sharing meetings; (c) the systematic collection and analysis of programme data improved results-based management; (d) skills training was useful to the extent that such skills were applied and a follow-up plan was in place to ensure desired impact; and(e) joint United Nations programmes were more effective.

3.2.2 The 7th Country Programme

Building on the lessons learnt from the 6th CP, the 7th CP was developed to contribute to the Kenya Vision 2030, within the context of the Kenya Joint Assistance Strategy (KJAS) and the five-year Medium Term Plan (MTP). The programming context embraced the principles of human rights, people-centered development, culture and ethics, gender equity and empowerment of women, increased national ownership, partnership and alliance building. The process of programming involved specific steps that began with the agreement on key development challenges at the national level, main programme strategies, the expected results and division of labour as well as securing resources for the proposed country programme through the Country Programme Document (CPD). This was followed by the development of the Country Programme Action Plan (CPAP) drawing heavily from the CPD as well as responding to UNDAF outcomes while ensuring linkages with the UNFPA Strategic Plan. To implement the Country Plan of Action (CPAP), Annual Work Plans (AWPs) were drawn by implementing partners with the support of UNFPA.

The 7th Country Programme responded to priorities linked to the social and political pillars of the Kenya Vision 2030. The CP contributed to three of the six UNDAF outcomes. The goal of the 7CP was "to contribute to the improvement of the quality of life of the people of Kenya". The CP also contributed to the implementation of the First Medium Term Plan – the first operational plan for vision 2030. The CP wasto be implemented through the following strategies: 1) capacity enhancement; 2) promotion of use of a knowledge base; 3) reinforcing advocacy and policy dialogue; 4) expanding and strengthening partnerships; and 5) developing systems for improving performance.

The CP implementation was guided by the spirit of "Delivering as One UN" initiative through joint programming with sister UN agencies and other development partners. Table 4 reports the CP outputs, outcomes and UNDAF outcomes.

3.2.3 The Kenya Country Programme Financial Structure

The 7thCountry Programme was guided by the external resources policy of the Government. The programme was approved for USD 32.5 million of which USD 25.5 million was to be obtained from regular resources and USD 7 million through co-financing modalities and/or other resources. The financial resources were distributedas shown in Table 5.

Table 5: UNFPA - Kenya Country Programme Budget, 2009-2013

Focus Areas	Core Funds	Non-Core Funds	Total
Reproductive Health	11,400,000	3,500,000	14,900,000
Population&Development	3,900,000	2,500,000	6,400,000
Gender Equality	3,900,000	1,000,000	4,900,000
Programme Management	6,300,000	-	6,300,000
Total	**25,500,000**	**7,000,000**	**32,500,000**

All cash transfers to implementing partners were based on Annual Work Plans agreed upon by UNFPA and implementing partners.The progress to date in resource mobilisation is shown in Table 6.

Table 6: Update of Resource Allocation and Mobilisation

Non-Core Target: 7,000,000		Core Target: 25,500,000	
Year	**Allocations**	**Year**	**Allocations**
2009	2,982,313	2009	5,045,000
2010	2,269,495	2010	5,099,995
2011	1,248,533	2011	5,550,000
Total	**6,500,341**	**Total**	**15,694,995**

The non-core resources were received from various sources to support activities in a variety ofareas of need. For example, funds from DFID were channeledtowards HIV and AIDS, the Maternal Health Trust Fund (MHTF) was earmarked for obstetric fistula while the Humanitarian Response was supported with funds from UNFPA (HQ). The Core Resources were increased by USD 400,000 and this was directed towards humanitarian response in 2011-2012. The Kenyanational census received support from SIDA and UNICEF,while GBV was funded by DANIDA andNorway. The FGM/C global campaign received funding from UNICEF and Norway and the Youth and FP was supported by Packard Foundation. In terms of leverage of resources the Reproductive Health portion of the GOK/State Health Budget was increased to 2.58 percent in 2009/10 from 0.17 percent in 2005/06. Overall there wasan annual increase in State Health Budget (USD 51.6 million in 2005 against USD 1.2 billion in 2010).

Financial Resources Mobilisation, Allocation, Disbursement and Expenditure

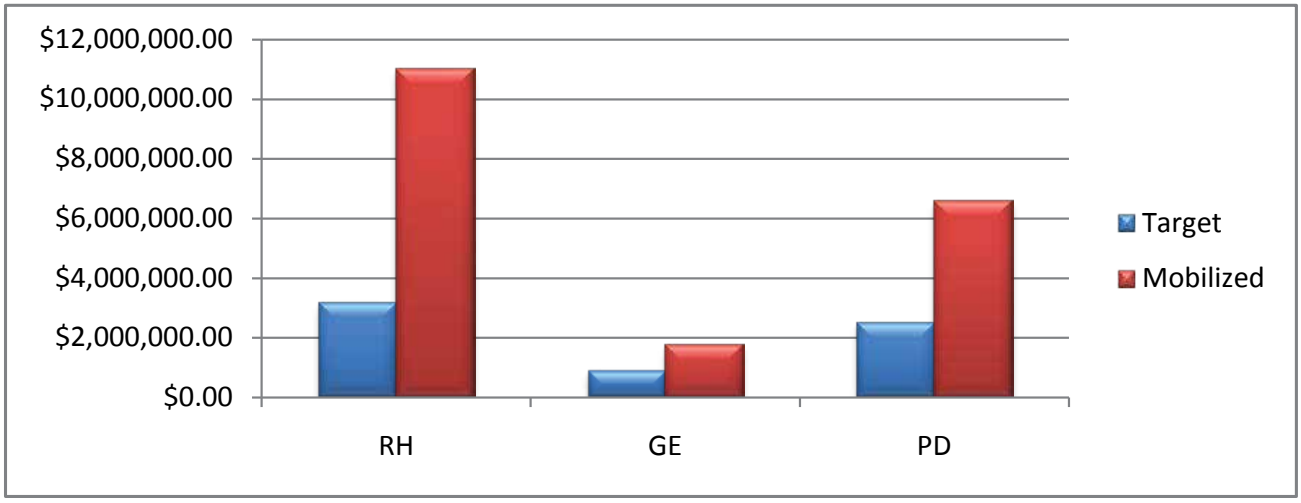
Resource Mobilization for the 7th CP

In 2010, theKenya Country Office developed a comprehensive strategy for resource mobilisation which was regularly refined and updated in line with the UNFPA Strategic Plan in response to programme needs. The main objectives of resource mobilisation were to: a) identify the funding needs of UNFPA KCO and IPs and prioritise for the same; b) identify corresponding needs with regard to above donor priorities and funding opportunities; c) develop quality concept notes and funding proposals; d) enhance communications and partnerships; e) increase visibility of UNFPA KCO and its programme of assistance; f) enhance advocacy; g) use aid effectively and leverage resources; h) demonstrate transparency and accountability in the utilisation of mobilised and/or leveraged resources and, i) ensure and strengthen office resource mobilisation capacities.

Target versus Mobilized 2009-2012 for all Components

The 7th CP total budget was estimated at USD 32.5 million. A proportionately large share of this budget (USD 25million) was obtained from regular resources, while the remaining USD 7million originated from non-core resources. Over the programme cycle, UNFPA funds mobilisation exceeded the target resources for all components; the highest mobilisation rate being for RH (i.e. 3.35) followed by PD (with 2.63) and then GE at 1.98. This resulted into an average mobilisation rate of 2.94 for all components during the same period. Figure 4 shows the 7th CP target resources and corresponding mobilised funds for the period 2009-2012

Figure 4: Targeted Resources and Mobilised Resources for all Components for the Period 2009-2012

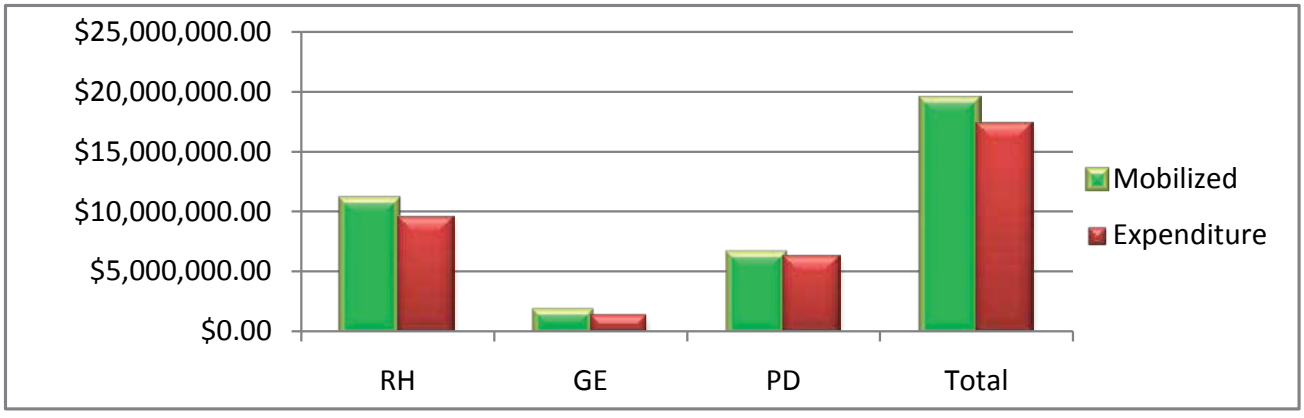


Source: **UNFPA**

Mobilised versus Expended Resources for all Components 2009-2012

The use of mobilised resources was good for the CP over thefour years at an overall implementation rate of 89.91 percent. The PD component's expenditure as compared to the mobilized resources was the highest with an implementation rate of 96.43 percent, whereas GE registered the lowest expenditure as a ratio of mobilised resources at 81.91 percent. Figure 5 shows the mobilised andexpended resources for all components over the period 2009-2012.

Figure 5: Mobilised and Expended Resources for the 7thCP 2009-2012



*Source:***UNFPA**

The estimated implementation rates per component per year are reported in Table 7. The table shows that during the year 2009, GE component expended more than what was planned to register an implementation rate of 107.29 percent. The CP executed for the same year 90 percent of its planned activities, while the CP overall accomplishment rate in 2010 was slightly above the average at 66.6 percent. This was caused by a poor performance rate by RH

component of 44.57 percent. However, RH in 2011 took the lead in executing all the planned activities to register an implementation rate of 102.63 percent. PD and GE executed planned activities at 95.94 percent and 91.28 percent respectively. GE performed dismally in 2012 at 56.45% but in the same year PD registered 93.26 percent.

Table 7: Implementation Rates for the Period 2009-2012

Components	2009	2010	2011	2012	Overall Implementation Rate
RH	81.51%	44.57%	102.63%	91.91%	87.31%
PD	93.07%	75.68%	95.94%	93.26%	96.43%
GE	107.29%	98.12%	91.28%	56.45%	81.91%
All Components	90.06%	66.66%	97.58%	89.91%	89.91%

Source: **UNFPA**

Results from Table 7 show that the year 2010 was the worst in terms of efficient programme execution while year 2011 was the best. Over the entire programme cycle, The PD component registered the highest average rate of implementation, while the GE component registered the lowest. Incidentally, GE's highest rate of execution was attained in 2010, which was the worst year of the cycle.

Component Allocation as a Share of Total Budget

The 7th CP had a budget of USD 32.5 million out of which USD 25.5 million were obtained from regular resources. The RH component accounted for the highest allocation of both core and non-core resources at USD 11.4 million and USD 3.5 million respectively. The PD and GE components received equal allocation from core resources of $ 3.9 million. Figure 6 shows the budget for the 7th CP per component by source of funds.

Figure 6: 7thCP Budget per Component and by Source of Funds

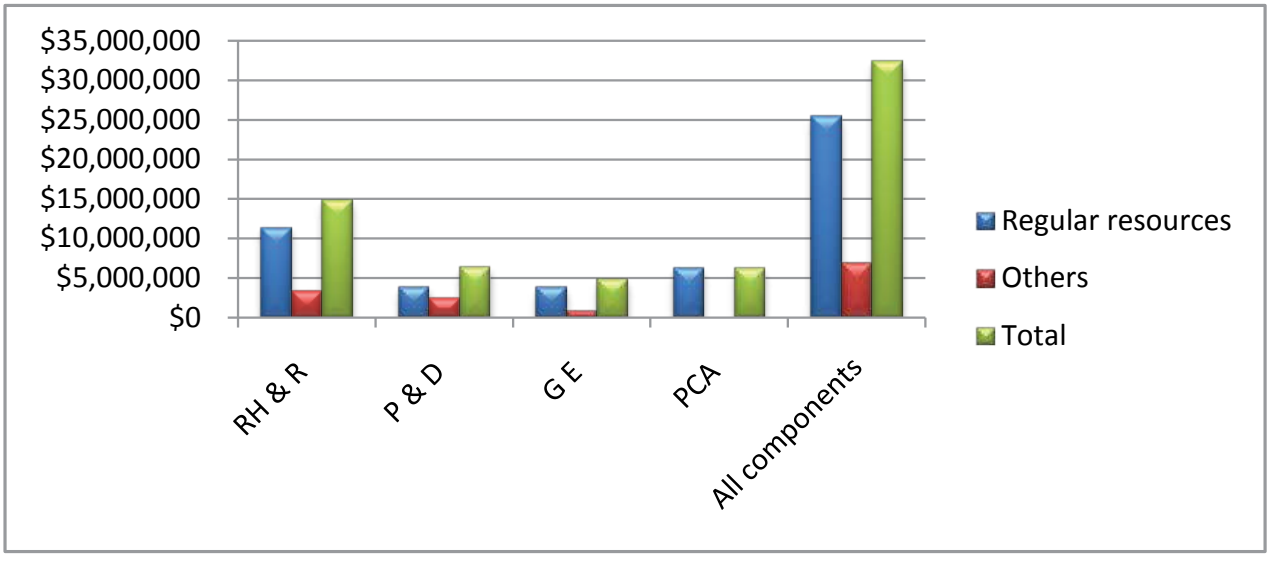
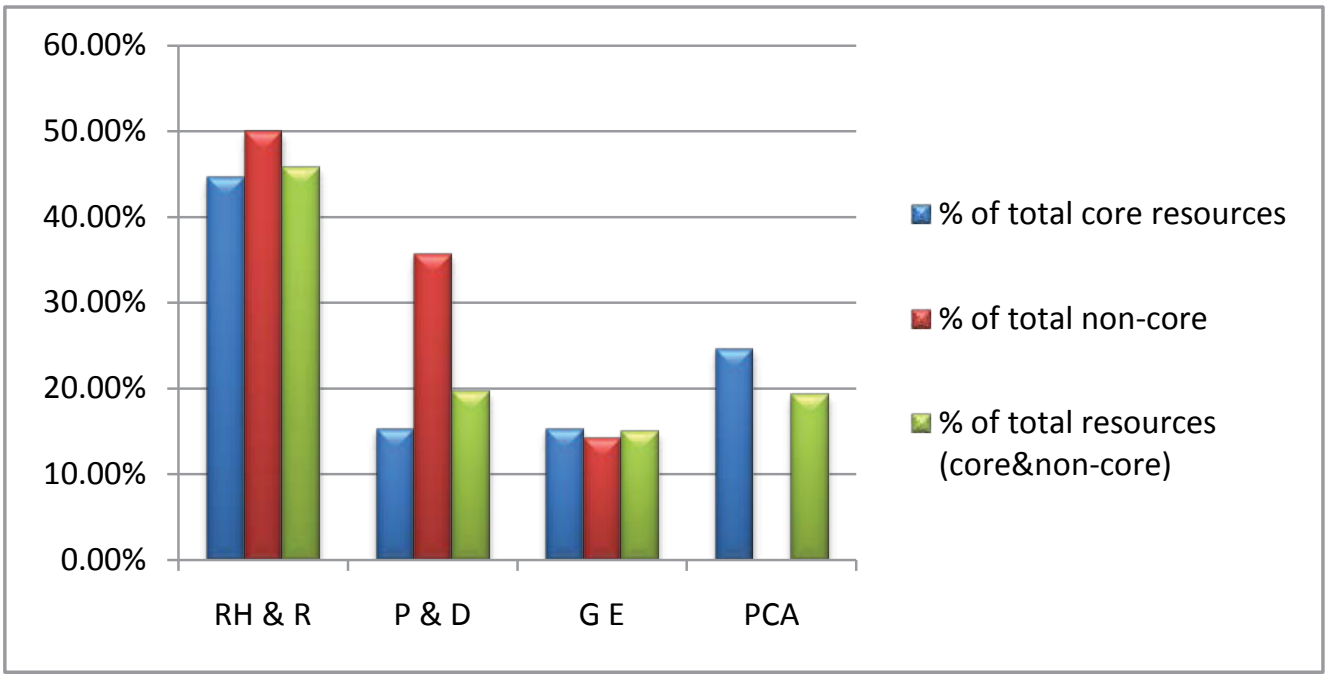


Figure 7 shows resources allocated per component as a share of the total 7th CP budget. Looked at as a percentage of total allocated budgets, the RH component received the largest shares of core, non-core and total budget respectively over the entire programme cycle at 47.7 percent, 50 percent and 45.85 percent respectively.The GE component on the other hand, received the lowest allocation as a percentage of all core, non-core and total budgets.

Figure 7: Shares of Allocated Funds per Component by Source of Funds



Source: **UNFPA**

Chapter FOUR

ANALYSIS OF THE PROGRAMMATIC AREAS

4.1 Introduction

This chapter presents the analysis of the 7th CP programmatic areas based on the evaluation criteria of relevance, effectiveness, efficiency and sustainability. This evaluation focuses on UNFPAs 7th CP for the period 2009-2013. However, it is important to note that this CPE has been conducted a year earlier (2012) as the CP was expected to end in 2013 and therefore programme activities are still on-going. The extension of the programme to 2014 is likely to realize achievements that may alter the current evaluation results. Although the change in the strategic approach after 2011 calls for a cluster approach, the evaluation criteria is applied to the three programme areas up to the period December 2012 to reflect what was evident on the ground operationally. The information used in the analysis of this section was obtained from documents provided by the Kenya Country Office; comprising UNFPA 6th CP evaluation and summary; programme design documents, annual work plans, annual reports, mid-term review report (2011); government policy documents and strategic plans. Primary data was obtained from conducting selected interviews with implementing partners, programme managers, government officials and programme beneficiaries.

4.2 Reproductive Health

The Reproductive health and rights component focused on three programme outputs aimed at increasing availability of maternal health services namely: prevention and management of obstetric fistula, instituting gender sensitive and culturally sensitive behaviour change interventions for RH including FP and FGM; and increasing availability of high quality services to prevent HIV and STI infections. The target of these interventions was skewed towards women, young people and other vulnerable groups in line with the strategic focus of the Vision 2030 and UNFPA strategic plan(2009- 2013). The analysis of the Reproductive Health and Rights component is categorized under relevance, effectiveness, efficiency and sustainability.

4.2.1 Relevance

To what extent are the objectives of the 7th CP aligned to the objectives of MTP1 and the Vision 2030? To what extent does UNFPA support to Kenya respond to individual beneficiary requirement and to national priorities?

The Reproductive Health and Rights outputs of the 7th CP responded to two UNDAF outcomes addressing health priorities outlined in the Kenya Health Policy framework (1994, 2012-2030), the National Health Sector Strategic Plan (NHSSP II (2005-2012) and HSSIP (2012-2016). The RHR component was in line with the National Reproductive Health Policy (2007), the adolescent reproductive health and development policy (2003) and Plan of action (2005-2015) and Reproductive Health Commodity Security 2007 (revised 2012). Other policy documents and guidelines are outlined in chapter 2 of this evaluation. The Constitution of Kenya 2010 articulates human rights broadly, with particular attention to health and gender equality. The Reproductive health and rights component of the CP addressed three outputs geared towards supporting national health sector priorities as a way of contributing to the realization of MDG 5.

The planned interventions in the 7th CP were relevant and met the needs, policies and priorities of a wide range of stakeholders and target groups. A review of the Road Map for accelerating the attainment of MDGs relating to maternal and newborn health showed that Kenya was one of the countries making no progress in the reduction of MMR (WHO, 2012)[3]. In an effort to address this problem the GOK developed a maternal and newborn care road map and facilitated identification of high impact interventions by the MOPHS. The 7th Country programme was aligned to the GOK commitment

3 Trends in Maternal Mortality 1990-2010: WHO, UNICEF, UNFPA. The World Bank Estimates (WHO, 2012)

to address MDG 5(a and b) by providing quality care and increasing access to reproductive health services. During the 7th Country Programme capacity building of MOPH staff and infrastructure development of health facilities took place.

The programme focus on youth reproductive health responded to the government commitment on addressing the health needs of this category of the population as a vulnerable group. This is outlined in the policy document of 2003 and the revised plan of action of 2012-2015; and is reflected in the support for establishment of youth empowerment centres and advocacy for provision of youth friendly services.

Although positive strides were made in reducing HIV prevalence, HIV remains a major public health challenge in particular to the vulnerable groups such as MARPS and sex workers. The programme focus on these groups recognized the need to provide services and to institute behavior change through HIV risk reduction and empowerment of communities, in line with the GOK policy of meeting the needs of vulnerable groups and reduction of HIV prevalence.

The 7th CP supported the development, printing and dissemination of several policies that contributed towards addressing national priorities in reproductive health and rights. These included - the National Reproductive Health Policy (2007), the National Reproductive Health Strategy (2009-2015), the National Road Map for Accelerating the attainment of MDGs relating to Maternal and Newborn Health in Kenya (2010), the National Guidelines for community midwifery (2006), National Family Planning Guidelines and the National Condom Strategy. Others included - Contraceptive Commodity Security Strategy 2007(revised 2012), National Reproductive Health HIV and AIDS Integration Strategy 2009, National Guidelines for HIV/STI Programmes for Sex Workers, National Contraceptive Commodity Security Strategy 2007-2012, Kenya National AIDS Strategic Plan 2009-2012/13, Youth Dialogue Tool (MOYAs 2011) and Support for curriculum review for department of Obstetrics and Gynecology within the Medical School, College of Health sciences, University of Nairobi.

4.2.2 Effectiveness

To what extent were the expected outputs of the CP achieved? To what extent were the planned geographic area and targeted groups of beneficiaries reached by UNFPA support? Are there any unintended effects of such support; whether negative or positive?

Effectiveness as defined in this CPE is the degree of achievement of outputs and the extent to which outputs have contributed to achievement of the CPAP outcomes. This analysis is applied to each of the three outputs of the component of RH as outlined below.

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

The 7th CP outlined five lead activities that were used in the implementation of Output One which consisted of the following:

- Strengthening essential obstetric care and community midwifery to improve maternal health
- Prevention and Management of obstetric fistula
- Strengthening Reproductive Health commodity security
- Supporting reproductive health needs in humanitarian response situations
- Improving access of young people to integrated sexual and reproductive health and HIV prevention services

Achievements for the indicators for the above activities are shown in appendix 5.

Strengthening Essential Obstetric Care

The CP targets for increasing the proportion of sites offering Basic Emergency Obstetric Care (BEOC) were district specific. Available data show that for Migori district, there was a steady increase in the proportion of

facilities offering BEOC from a baseline of 10% in 2009 to 24% in 2010 to 69% in 2011 and 2012 against a target of 60% by 2013. For Migori district, this target was therefore met and surpassed. Kilifi district showed a slight increase in the proportion of facilities offering BEOC from 20 % (2009) to 38% (2012) against a target of 70% in 2013. For Naivasha, the increase was minimal from 10% in 2009 to 15% in 2011/2012 against a target of 62% in 2013. Both Kilifi and Naivasha districts were therefore unlikely to meet the set targets within the remaining programme period.

Strengthening EOC was addressed through training of health service providers in EOC, including use of the partograph that is critical in the management of labour. Data at the DRH showed that 120 health service providers had been trained in EOC. In Kilifi district, service providers received training in the following areas: ENC (35), FANC/MIP/TB (39), RH /HIV integration (47), cervical cancer screening (32) compared to ENC (1), FANC/MIP/TB (11), RH /HIV integration (2), cervical cancer screening for Migori district (9). This evaluation in addition assessed the ability of district health facility within the focus districts to offer quality services in relation to the signal functions of Basic and Comprehensive Emergency Obstetric Care (CemOC). Migori district hospital did not perform vacuum delivery while Kilifi and Naivasha district hospitals were able to perform all the 9 signal functions.

This evaluation also covered skills and the presence of job aids, infrastructure as well as relevant materials for clients to take home. Table 8 shows some of the necessary elements found to be available at the health facilities by district. Of the three districts, Kilifi was the better endowed in terms of availability of key items including complete delivery sets; followed by Naivasha while Migori had fewer complete delivery sets. Naivasha and Migori did not have IEC materials on display covering danger signs on pregnancy, newborn and action to be taken at the health facility and at home. Nairobi West, represented by Riruta health centre had much fewer items and this we attributed to its health centre status.

Table 8: HSP Training and Availability of Essential Equipment, Guidelines and Functionality of YFS and YEC in the Four Targeted Districts

Item	Migori	Kilifi	Naivasha
SP trained in EOC	3	4	15
SP trained in ENC	1	1	7
No of complete delivery sets available	8	20	17
Availability of Nursery for newborn babies	Yes	Yes	Yes
Availability of Incinerator/ Placenta pit	Yes	Yes	Yes
Guidelines/Job Aids for AMTSL on display in labour ward	No	Yes	No
Guidelines/Job Aids for ENC on display in labour ward	Yes	Yes	Yes
Essential newborn care	Yes	Yes	Yes
Post abortion care	No	Yes	Yes
Clinical training skills	No	Yes	No
IEC materials on newborn danger signs and action to take displayed at facility	No	Yes	No
IEC materials on newborn danger signs and action to take home	No	Yes	No
Youth Friendly Centers	Non-functional	Non-functional	Non-functional
Youth Empowerment Centers	Functional	Non-functional	Non-functional

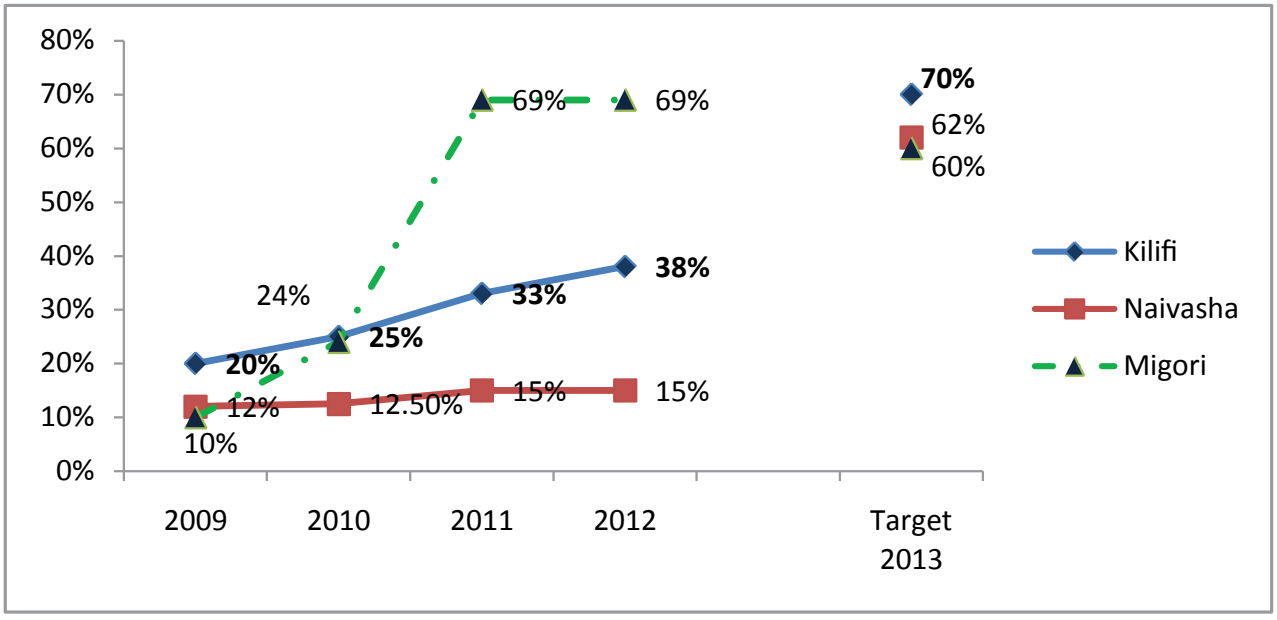
This evaluation assessed the ability of district health facility within the focus districts to offer quality services in relation to the signal functions of Basic and Comprehensive Emergency Obstetric Care (CemOC). Table 9 reports the performance of selected health facilities in EmOC signal function.

Table 9: Performance of Selected Health Facilities in Relation to EmOC Signal Functions

EmOC Signal Function	Migori	Kilifi	Naivasha
Administer parenteral antibiotics	Yes	Yes	Yes
Administer uterotonic drugs2 (i.e. parenteral oxytocin)	Yes	Yes	Yes
Administer parenteral anticonvulsants for preeclampsia and eclampsia (i.e. magnesium sulfate)	Yes	Yes	Yes
Manually remove the placenta	Yes	Yes	Yes
Remove retained products (e.g. manual vacuum extraction, dilation and curettage)	Yes	Yes	Yes
Perform assisted vaginal delivery (e.g. vacuum extraction, forceps delivery)	No	Yes	Yes
Perform basic neonatal resuscitation (e.g. with bag and mask)	Yes	Yes	Yes
Perform surgery (e.g. caesarean section)	Yes	Yes	Yes
Perform blood transfusion	Yes	Yes	Yes
Does the facility conduct maternal death Reviews?	Yes	Yes	Yes

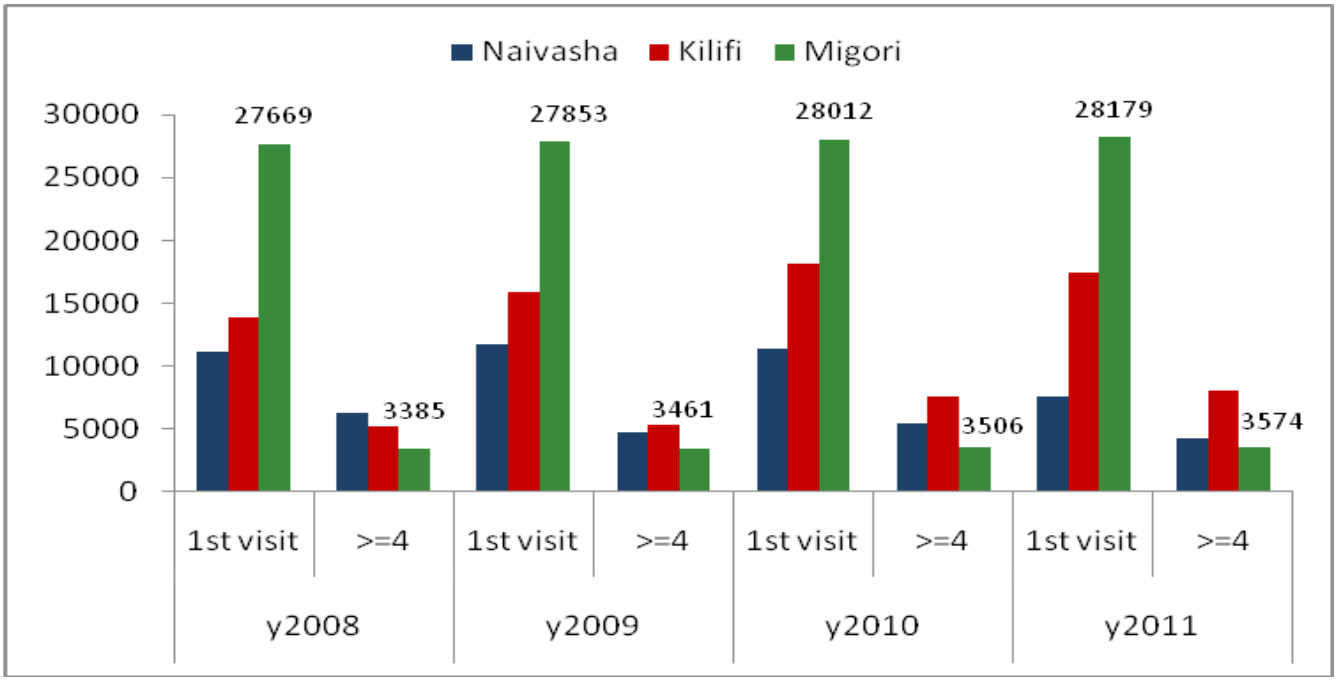
In this regard, Migori district hospital did not perform vacuum delivery while Kilifi and Naivasha district hospitals were able to perform all the 9 signal functions. Nairobi West (Riruta) health centre was not expected to provide comprehensive EmOC services due to its health centre status and was therefore only expected to conduct normal deliveries but not C-sections. Figure 8 shows the percentage of sites offering BEOC.

Figure 8: Percentage of Sites Offering Basic Emergency Obstetric Care (BEOC)



Antenatal attendance and particularly focused ante-natal care (4 visits) is important and contributes to the outcome of newborn and maternal health. **Figure 9** shows the number of clients attending first and fourth ANC visits by district. In all the three districts the attendance for the recommended 4th visit was far much lower than those who came for the first visit especially for Migori district. In all the districts it was reported that CHWs were instrumental in encouraging pregnant mothers to attend ANC but that more emphasis needed to be placed on early timing of first time visit and attendance of ANC for a minimum of four visits.

Figure 9: No of Clients Attending 1st and 4th ANC Visits by District



The 7thCP support for trainings in EOC improved the skills of health workers leading to positive changes in the management of labour and delivery. Service statistics showed a mixed trend in the utilization of skilled delivery service across the three target districts. Migori showed no improvement across the four years, Kilifi showed a marginal increment while Naivasha showed a decline from year 2009. Part of the drop could be explained by the fact that the original districts had since been sub-divided into smaller districts thus independently reporting new and fewer numbers of expected deliveries. This change in the target districts was not revised in the CP targets accordingly.

Support for community midwifery was identified as one of the strategies to improve safe motherhood through skilled birth attendance so as to avert disabilities such as obstetric fistula. In 2006, during the 6th CP, UNFPA supported MOPHS through Population Council to develop community midwifery guidelines for training community midwives (MOH, 2012[4]). The 7th CP supported the training of 143 community midwives, (Migori-54, Kilifi 19, Naivasha 20 and Nairobi West 60) against a target of 315.

The contribution to skilled attendance that can be attributed to community midwives has not been well documented by MOH and other implementing partners; with the exception of Nairobi West (Riruta H/C). Marie Stopes Kenya (MSK) while initiating training of community midwives envisaged that they would be able to conduct 800 deliveries altogether but this was not followed up once MSK discontinued its partnership within the programme. The 2009

4 MOH, 2012; Community Midwifery services in Kenya.Implementation Guidelines.Second edition – August 2012.http://iframe.k4health.org/sites/default/files/Community%20Midwifery%20%20Services%20in%20Kenya_Implementation%20Guidelines.pdf

annual report for Marie Stopes Kenya (MSK) indicated that a total of 262 deliveries were conducted by trained community midwives in 2009. The Community Midwives also referred 93 mothers with complications to health facilities, provided ANC services to 1,480 mothers and PNC to 459 mothers. It is plausible that if the community midwives had been monitored, going by the performance in 2009 they may have been close to the target of 800 deliveries by the time of the current evaluation. Available data from Kangemi, Kawangware and Kibera slums within Nairobi West district showed an upward trend in the number of deliveries conducted by community midwives over a two year period.

The community midwifery initiative faced several challenges including: reluctance by community members to pay for delivery services, lack of transport for referral, security concerns and shortage of retired health care providers in some communities. Some community midwives also seemed to prefer private practice in urban settings to rural communities where the need for their services was greater in the latter. In addition to these challenges is the reliance of community midwives on health facilities for supplies and supervision both of which may not always be available. Community midwives also need to upgrade their skills to improve their capacity. The success of the community midwifery initiative can be attributed to the government buy-in following the pilot phase. The participation of the community midwives in referral though not monitored did contribute to reduction in maternal deaths.

Prevention and Management of Obstetric Fistula

The prevention and management of obstetric fistula was undertaken at facility and community levels with the latter being addressed in output 2. The 7th CP supported facility level interventions that included: training of surgeon-nurse teams, procurement of OF kits for referral hospitals and conducting of 6 OF repair camps nationally. The bulk of these activities were conducted in 2009 with a total of 101 health workers trained. Cadres of health workers trained included 23 doctors, 10 anesthetists, 10 physiotherapists, 58 nurses and 1 social worker. Training for more specialized skills on fistula repair was undertaken in Ethiopia by two surgeons one of whom is currently a key trainer in OF; based at the Nyanza Provincial General Hospital and the other at Coast Provincial General hospital. Over the program period, 755 Obstetric Fistula Kits were procured and distributed nationally (see appendix 2). As part of decentralizing the surgical management of OF in district hospitals with already trained teams, UNFPA supplied 6 district hospitals with operating tables and OF kits. The six were Kisumu, Migori, Mbale, Webuye, Siaya and Muranga District hospitals. These capacity building initiatives enabled major referral hospitals to conduct OF repair surgery, thus expanding access to services for OF clients, even though not on a routine basis.

The 7th CP set a target of successfully repairing 1500 OF clients. However, the programme managed to repair 705 clients to date with 39% of these being integrated back into the community. The OF repair camps were conducted mainly in 2009 and this was not replicated in subsequent years at the same scale due to high costs of repair camps. OF cases repaired declined on an annual basis due to a change in the strategy from holding camps to integration with other services at the referral health facilities. Although it was envisaged that repairs would be available at district hospitals this was not possible due to various challenges: the major factor being that fistula repairs, though desired are in practice not integrated in routine facility service delivery. Obstetric Fistula has now been recognised as a priority area in maternal and newborn health by the Ministries of Health. MOPHs data collection tools are now being reviewed to specifically capture OF cases rather than have them captured under the "others" category.

Strengthening Reproductive Health Commodity Security

UNFPA is a key player in strengthening reproductive health commodity security in addition to being a member of the FP Commodities Logistics Team whose membership is drawn from DRH, KEMSA, KFW, MSH and other partners. Through the programme support and in collaboration with other partners the national level staff acquired skills for forecasting and quantification of commodities which proved useful in the development of contraceptive commodity security strategy. The programme supported the development of the National Contraceptive Security Strategic Plan 2007 (reviewed in 2012) which provided a mechanism towards sustainable budgeting. For example in 2011 the Government purchased 80% of the required family planning commodities (cited in UNFPA Kenya

country case study report 2012). This was a notable improvement from the 6th Country Programme when MoPHs partnered with UNFPA, USAID and KfW in a sector-wide approach arrangement for procurement of family planning commodities; with the Government contributing about 50%, UNFPA 25-30%, USAID 10-20% and KfW 10% of the funds.

In the discussion with the FP programme manager at the DRH it was noted that the 7th Country programme facilitated the procurement of 2.5 million vials of DMPA within the 2012 financial year. On an annual basis, UNFPA supported the procurement of condoms (150 million male condoms and 1.5 million female condoms) through NACC as part of the World Bank supported TOWA programme. It also facilitated implementation of the condom policy, which ensured condom availability, access and wider use. The key challenge to RHCS logistics was the inability of the Kenyan Medical Supplies Agency (KEMSA) to distribute the commodities in a timely manner due to inadequate capitalization.

At the national level (DRH), the programme supported printing and dissemination of FP guidelines, procurement of family planning commodities (female condoms, DMPA kits, Progesterone implants, combined oral contraceptives, emergency contraceptives), technical working group meetings in FP, training of 3 programme officers on advocacy and two breakfast advocacy meetings with parliamentarians to lobby for increased funding for contraceptives. The programme also supported procurement of office equipment and computers to strengthen the FP programme in addition to supporting NASCOP with regard to procurement of office equipment, vehicles for program coordination, 3 trucks, 1 lorry for condom distribution and advocacy activities.

In 2012, UNFPA supported the process of strengthening reporting on commodity status in the four target districts through a project named "FP SMS reporting". This was initiated at the end of July 2012 with the sensitization of districts which had developed work plans and were awaiting financial support. This initiative was expected to improve reporting in Dhis2. Due to reorganization of the Contraceptive Management Unit (CMU) in DRH, the Logistic Management Information System (LMIS) was phased out and replaced by the District Health Information System (Dhis2).

Supporting Reproductive Health needs in Humanitarian Response Situations

Humanitarian assistance is critical due to Kenya's geographic location as a home for refugees from neighbouring countries and also due to the presence of internally displaced persons arising from conflicts and perennial natural disasters. Services to these vulnerable populations have traditionally focused on food and shelter and far much less on sexual reproductive health needs. UNFPA expanded its mandate to embrace disaster preparedness and timely response to SRH (including GBV, HIV/AIDS) needs in humanitarian situations. The support framework included the Ministry of Public Health and Sanitation (DRH and Division of Emergency and Disaster Management-DEDM), Kenya Red Cross Society (KRCS) and International Rescue Committee (IRC). This support was triggered by the expansive needs after the crisis precipitated by the 2007 post election violence and the growing number of IDPs in the country. The support later expanded to incorporate other disaster prone areas affected by natural disasters such as floods and droughts.

During the 7th CP, support to humanitarian response included training of RH focal persons on Minimum Initial Service Package (MISP) and provision of emergency RH kits.[5] The programme supported the training of 215 focal persons on MISP against a target of 450, a shortfall of 235 from the target. In 2010/2011, KRC targeted training of 200 RH focal persons on MISP but all trainings were cancelled and funds diverted to emergency response during floods. Emergency RH Kits were procured for 8 provincial hospitals and 4 districts. Nationally 8 KRCS warehouses were pre-positioned with emergency kits for rapid response and 6,870 dignity/hygiene kits were procured, pre-positioned and distributed. However, the dignity kits procured were still inadequate due to high demand. Beneficiaries, particularly women appreciated the dignity kits, but the current distribution of one kit per household rather than by number of individuals and

5 Reproductive Health Kits have been primarily designed to facilitate the provision of priority reproductive health services to displaced populations without medical facilities, or where medical facilities are disrupted during a crisis. They contain essential drugs, supplies and equipment to be used for a limited period of time and a specific number of people.

gender in the household was found to be inadequate and we recommend that this approach be revised appropriately.

With support from the programme, KRCS continued to provide a wide range of services in emergency situations including integrated medical services (reaching 11,775), HIV counseling and testing (3,211), trauma counselling (5,940), SRH/GBV/HIV/AIDS (2,148), MCH/ANC (1,932), peer education sessions and health promotion talks (1,035). It is expected that in futurethe programme's support in humanitarian response will be stepped up in Dadaab by establishing field presence.

Improve Access of Young People to Integrated Sexual and Reproductive Health and HIV Prevention Services

The programme targeted establishing 4 youth friendly centers (YFC) and 4 Youth Empowerment Centers (YEC) in each of the focal districts. All the four YFC and four YEC were established/renovated as planned. However, only two of the YFC (Nairobi West and Naivasha) and one of the YEC (Migori) were functional. Delays in equipping the YECs and YFCs were experienced due to lengthy procurement procedures. Working in collaboration with other NGOs and CBOs such as FHOK and MUMCOP, the CP also supported youth activities to increase access to integrated SRH and HIV related services. Beyond service provision, the youth centers also provided recreational activities, vocational skills such as ICT training and library resources for reference. In Mumias at the MUMCOP offices the youth engaged in income generating activities.

According to FHOK report (2009-2012), the programme reached 41,092 young people with integrated FP/RH/STI information and services. Between 2009 and 2010, a total of 6,147 young people received HIV counseling and testing; family planning, Pap smear – 480, and STI -treatment services-580. For example, between 2010 and 2011, a steady increase in the number of youth accessing VCT and FP services was observed at Riruta Health Centre.

The youth centers under MUMCOP and FHOK provided more comprehensive services, ranging from VCT services, skills development and entrepreneurship, library resources and computers for internet access; with a focus on peer education and activities that emphasize skill and personal growth. Consequently from the activities arranged by MUMCOP, some youth joined professional football clubs. Through FHOK the programme supported training of young people on life skills (30), community youth leaders on YFS (30) and young people on life skills (6,486). These activities led to the creation of an enabling environment for young people to access SRH and HIV services as well as vocational skills in a one- stop shop.

The 7th CP worked in collaboration with the Ministry of Youth Affairs to disseminate various youth policy documents and action plans in all the 8 provinces and the focus districts. These included: Action Plan for Youth and Health and the Kenya Youth Dialogue tool. The programme also conducted capacity building and sensitization workshops for youth leaders, youth programmers, and opinion leaders drawn from the focus districts on sexual reproductive health and rights, family planning, HIV prevention, teenage pregnancy, FGM and abortion. Consequently, a total of 5,053 youth and youth leaders, and 320 opinion leaders were trained.

Youth Friendly Centre at Nyamaraga- Migori – Completed but awaiting equipment

Resource centre/library at MUMCOP

Model Health Centre (MHCs)

The 7th CP supported the Ministry of Public Health and Sanitation to commission a study whose recommendations included the establishment of model health centre/centers of excellence. The centers were expected to serve as models of excellence in delivery of quality integrated health/reproductive health services but more importantly to motivate women to demand and utilize these facilities during labor and early neonatal period. All the health centers were offering integrated SRH services: modern family planning methods including permanent and long term methods driven by outreach camps by MSK; safe deliveries, emergency obstetric care, STI, HIV counseling and testing, referral and outreach. The provision of youth friendly services was available in only two of the MHCs.

In line with the MOH focus on access to services and quality care, the programme supported the setting up of four Model Health Centres, one in each district. The support was extended to infrastructure development including renovation/refurbishment of health facilities: maternity units, operating theatres, procurement of equipment (delivery packs, delivery beds) and supplies (ANC laboratory reagents) to facilitate comprehensive ANC service provision. With support of the programme the referral system within the focus districts were strengthened through the procurement of 6 ambulances (Kilifi-1, Migori-1, Naivasha-1) N/West -3), with the GOK providing fuel and drivers.

Based on field visits and discussions with the DHMT it was evident that though renovations of Model Health Centers were undertaken in 2010, they were not fully functional due to lack of equipment and adequate staff. It was therefore not possible to assess the real contribution of MHCs to the provision of quality services during this evaluation. However, there were indications that demand for services existed as demonstrated by Mtwapa HC which, upon commencement of providing maternity services in 2012 recorded 2 deliveries in April. This rose to 20 deliveries in May 2012, by June 2012, the deliveries had increased to 27 in the month. A monitoring visit by UNFPA in September 2012 recorded 40 safe deliveries. By 2012, Nyamaraga in Migori was registering 12 deliveries per month up from 3 while Ndabibi in Naivasha had 5 deliveries per month up from none.

The concept of Model Health Centers was consequently embraced by the Ministry of Health whose target was to set up one MHC in each constituency. Deliveries in the MHCs did improve greatly especially in the fully functional ones.

Newly Acquired Ambulance for Mtwapa MHC

New maternity wing at Nyamaraga MHC

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

This output was addressed through 3 activities:

- Engaging communities to change negative socio-cultural norms and practices affecting SRH and transmission of HIV
- Advocacy for the Prevention and Management of Obstetric Fistula
- Revitalization of Family Planning

The major activities, indicators, targets and achievements for this output are reported in appendix 6.

Engaging Communities to Change Negative Socio-Cultural Norms and Practices Affecting SRH and Transmission of HIV

At the time of evaluation in mid-2012 there were a total of ten IPs implementing behavior change activities. With the extension of the programme to 2014 there is a likelihood that the target of 13 IPs will be achieved. These IPs were instrumental in spearheading peer education and outreach activities to address negative socio-cultural practices such as early marriages and FGM that are precursors of OF. Regarding HIV transmission, NACC focused on addressing retrogressive harmful practices and stigma by calling for social transformation through a redefinition of roles. While in Kilifi, CHWs were used to discourage traditional harmful practice of abdominal massage during pregnancy and instead encouraged pregnant women to attend ANC and deliver in health facilities. Details on socio-cultural norms and practices are largely covered in the Gender Equality section of this report. The activities under this output may have contributed to enactment of the FGM Act 2011.

Advocacy for the Prevention and Management of Obstetric Fistula

Under the 7th country programme, community level interventions for the prevention and management of obstetric fistula were led by three CBOs; MUMCOP in Western Kenya, Council of Imams and Preachers of Kenya (CIPK) in Coast and CDN in the Rift Valley. They focused on community mobilization,awareness creation, referral and support for reintegration of Obstetric Fistula survivors. A total of 258 clients were referred for OF repair by the time of the evaluation against a target of 600. The low referral rate could be attributed to the slowdown in OF repair from 2010 onwards as a result of the high cost of repair. The use of radio as a platform for advocacy on obstetric fistula and drug abuse; sensitization meetings on OF prevention and management and the distribution of over 1000 Fistula fliers and other related IEC materials to target communities gave immense visibility to obstetric fistula in the communities within the programme areas.

Ambassadors of Hope at MUMCOP

Revitalization of Family Planning

Revitalization of family planning was undertaken at facility level and community levels. At facility level, it included training of health service providers in the provision of LAPM, procurement of FP supplies and LAPM kits. At the community level emphasis was laid on social mobilization, creation of awareness on available family planning services and provision of FP through outreach camps, the use of youth networks and youth peer educators. This was undertaken by various

Implementing Partners including, ICRH, MUMCOP, NCC, FHOK and MOYAs. Currently NCPD is investing resources on advocacy for revitalization of FP and the details are covered in the PD section of the report.

Through MSK, the programme supported the training of 91 Youth SRH TOTs as well as community midwives on FP. MSK was however only operational as an IP for one year. Within this period the uptake of FP services reached 4,075 clients; BTL (923); IUCD (496), implants (894), DMPA (1,050), pills (712). This was mainly achieved through mobile outreach services. With support from the programme 60 Community health extension workers/community midwives were providing family planning services against the set target of 48.

Over the programme cycle a declining trend in the use of Family Planning services by new users in the focal districts was noted. Among women of reproductive age, the proportion of new users of family planning in Kilifi district was relatively low. Across the focal districts, family planning uptake was highest in 2010 but these positive gains were reduced in 2011. A probable explanation is the reduction in the number of women of reproductive age within the catchment area as a result of subdivision of the districts into smaller units. The reduction in FP uptake could also be due to recurrent stock-out of FP commodities (depo and implants) at the facilities or the promotion of long term methods which may have also reduced new users annually. Data from Migori and Nairobi West show that there were months particularly in 2010 and 2011 when stock-outs of depo and implants were experienced, and this lasted up to six months thereby impacting on utilization(see appendix 4a and 4b). It is expected that improvement in the stocks and uptake of FP by new users would occur with the introduction of PAAL sms tracking system.

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

This output was addressed through the following activities:

- Comprehensive Condom Programming
- Scaling up of HIV and STI prevention skills and services
- Reducing HIV vulnerability in the context of Sex Work
- HIV prevention information, skills and services for young people.
- Behavior change communication for HIV prevention

The major activities, indicators, targets and achievements for this output are reported in appendix 7.

Comprehensive Condom Programming

Through the support of UNFPA, NACC and NASCOP a condom policy was put in place. Condom distribution surpassed the targets especially following the launch of *Zip it campaign* (male condoms) in 2011 that propelled condom use from 3 million to 12 million per month. Further support involved developing and printing materials on HIV targeting MARPs; quality assurance, condom promotion and procurement and distribution of condoms under TOWA. UNFPA's unique position of supporting emergency condom procurement during periods of condom shortage contributed significantly to condom security. NASCOP developed and disseminated guidelines and IEC materials and established a condom quality assurance system for routine sampling of condoms over the programme cycle. This was strengthened by capacity building for NASCOP through training of national staff on delivery training and DASCOS on comprehensive condom programming. In conjunction with NACC, the MARPS study and mapping of hotspots were conducted to inform targeting of MARPs with HIV information and services.

Scaling up HIV and STI Prevention Skills and Services

This intervention was largely undertaken by NGOs and CBOs in conjunction with NACC. With the support of the programme, ICPK reached approximately 50,000 youth, men, women and other vulnerable groups with messages on Reproductive Health, HIV/AIDS and Drug Abuse through radio programs and field visits. In addition, "youth corners" were established for young people to receive counselling services and information and to access recreational facilities. During 2009-2010, CIPK conducted VCT services to 620 clients who had been duly counselled.

HIV Prevention Information, Skills and Services for Young People

The target for reaching young people with RH information was set at 75,000 over the programme period. By 2012 this target had been surpassed, with ICRH contributing a majority (108, 763 out of 185,312) of the youth reached with services. The 7th CP supported capacity building workshops for youth programmers, youth leaders, implementing partners, parents/guardians, peer educators and members of youth networks (AFRIYAN) on sexual reproductive health issues including family planning, BCC and HIV prevention. Peer educators were also involved in creating awareness for services such as outreach mobile HCT; including moonlight. These initiatives led to capture of a considerable number of clients accessing HCT services.

Reducing HIV Vulnerability in the Context of Sex Work

At the national level the programme supported formulation of policy documents. These included the development of the Action Plan and programmatic guidelines for Gender mainstreaming action plan in tandem with KNASP III (2009/10-2012/13), Gender Response and Human rights manual in the context of HIV and AIDS, Human resource manual, Engendering of the Kenya National AIDS Council Bill, the National Condom Policy and the National Condom Promotion Strategy. The programme supported Kenya Women HIV prevention Symposium in 2010, a study tour to Vietnam and India in addition to supporting TWG for MARPs. It also established the national steering committee for MARPs to oversee mapping of sex work programmes and the conduct of a national situation analysis of commercial sex workers. In terms of support to capacity building UNFPA seconded two staff to NACC as NPPPs for MARPS and gender mainstreaming.

As a result of these activities, integration of gender dimensions in legislation (KNAC Bill, 2010) and other national HIV strategies/guidelines was achieved. National data on MARPS collected and a situation analysis report on SWs to strengthen youth networks developed. The activities also led to increased funding for gender mainstreaming activities in national HIV response accruing from the Global Fund Round 10 proposal in addition to triggering a comprehensive condom programming thereby enhancing RH/HIV integration and increasing use of condoms for control of STIs.

Through ICRH, the 7th CP supported the development of several strategies to engage sex workers, including recruitment and training of female sex workers (FSW) as peer educators in business management and Income Generating Activities (IGAs). In addition, a drop-in center was established as a "safe space" where sex workers, peers and clients met for information, services, condoms and lubricants without fear of repercussions or discrimination. The highlight of this intervention was to encourage young FSW to go back to school and to provide FSW with loans (approximately USD 100) for small businesses. This strategy empowered beneficiaries to negotiate for safer sex, to reduce the number of partners and to shift to consistent condom use to protect themselves and their partners. With an alternative source of income they became focused on securing education for their children as an exit strategy from poverty and as a way of ensuring that their children did not also trade in sex.

As a result of the activities of the 7th CP around sex work, the Government of Kenya acknowledged that SWs had reproductive health needs to be addressed. This triggered channeling of resources to sensitize health care providers and to provide these services.

Young Female Sex Workers who have returned back to School


FSW Peer educators displaying certificates for business training

Behavior Change Communication for HIV Prevention

Ten out of 13 IPs were engaged in behaviour change communication applying various strategies. Notable examples of IPs contribution included MOYAs Capacity-Building Workshops for Youth programmers and the 7thCP Implementing Partners (IPs) on Behaviour Change Communication (BCC). National AIDS Control Council established and strengthened Youth Networks on HIV and AIDS in Migori and Kilifi counties to provide a forum for exchange of information among peers. Members of the networks were trained in behaviour change communication (BCC), resource mobilization and proposal development to enhance their ability as change agents. The programme supported community based campaigns to sensitize and de-stigmatize HIV/AIDS. In MUMCOP the community leaders, including traditional (chiefs), religious and political (councillors) leaders were trained as advocates and role models for behaviour change with respect to HIV.

4.2.3 Efficiency

To what extent were activities and resources managed in such a manner as to ensure delivering of quality outputs in relation to resources used?

The 7th CP efficiency analysis covered the period 2009-2012 over which the relationship between mobilized and expended resources was assessed. Taking the most efficient level as 1.0 the RH component's most efficient level of disbursement was registered in 2011. In 2010, this component had the lowest disbursement efficiency at a level of 0.434 way below the mean efficiency level for the period, which stood at 0.768. Table 10 reports the estimated efficiency for the 7th CP.

Table 10: Estimated Efficiency across the 7th CP Years of Implementation for RH & R

Year of Implementation	RH Calculated Efficiency
2009	0.794
2010	0.434
2011	1.000
2012	0.845
Mean	0.768

Table 11: Efficiency Analysis by Use of Ratio of Expenditure to Mobilized Resources

Component	Implementation Ratio				Mean	Standard Deviation
	2009	2010	2011	2012		
RH	0.815149	0.445665	1.026321	0.919109	0.801561	0.2524421

The ratio analysis method (Expenditure/Mobilized) employed in Table 11, confirmed the year 2011 for RH as one with the highest implementation rate of 1.02, and year 2010 as one with the lowest implementation rate; a manifestation of higher disbursement inefficiency in the latter year. Table 12 reports efficiency comparisons between the 6th CP and the 7th CP. No clear trend of disbursement efficiency was discernible over the programme period, but on average, the table showed that the 6th CP was slightly more efficient in terms of disbursements.

Table 12: Efficiency Comparison for 6th and 7th CPs in their first Four Years of Implementation

Years of implementation	RH Efficiency		
	6th CP	7th CP	Mean
1st year (2004 vs. 2009)	0.774	1.000	0.887
2nd year (2005 vs. 2010)	1.000	0.474	0.737
3rd year (2006 vs. 2011)	0.895	1.000	0.973
4th year (2007vs 2012)	1.000	0.928	0.964

4.2.4 Sustainability

To what extent are the benefits likely to continue beyond programme termination?

Has UNFPA been able to support its partners and the beneficiaries in developing capacities, mechanisms to ensure durability of efforts? Were the activities, outputs designed taking into account a reasonable handover to local partners?

The RH&R outputs were addressed largely through government institutions and established NGOs and CBOs. Lobbying for allocation of more resources for RH and commodities from the government contributed not just to the recognition but also to the need to increase funding for RH. Consequently the government took up more responsibility in the purchase of over 60% of all the country's contraceptive needs using its own resources and 100% for both male and female condoms through a World Bank loan (TOWA). For example in 2011 the Government purchased 80% of the required family planning commodities (cited in UNFPA Kenya country case study report 2012). This was a notable improvement over the 6th Country Programme in which MoPHS partnered with UNFPA, USAID and KfW in a sector-wide approach arrangement for procurement of family planning commodities with the Government contributing about 50%, UNFPA 25-30%, USAID 10-20% and KfW 10% of the funds.

The government also seemed conscious of the need to address sustainability by ensuring that programme support was also aligned to government funding with the eventual absorption of the programme. For example in Naivasha there were discussions around the ministry taking over the fueling and provision of a driver for an ambulance that had been purchased through the 7th CP funding. This support was expected to come from the HSSF kitty. Similarly in Mtwapa the cost of running the ambulance was intended to be met by the health centre as well as Vipingo Health centre that also had access to the ambulance services. In Migori , the district hospital had plans to provide a driver for the ambulance at Nyamaraga centre of Excellence. The positioning of NPPPs within the IPs to spearhead capacity building and drive implementation of the programme were all activities geared at ensuring sustainability.

UNFPA was conscious of the need to address sustainability of programmes from the onset as is evident in the CP document that recognized that programmes be country-led. Thus the support for all the programmes was embedded in the country policy frameworks such that implementation became country-driven. Working through relevant ministries, UNFPA focused on supporting capacity building, training of core teams, development of curriculum and mainstreaming the same into existing curriculum to ensure institutionalization of training and capacity building. Key examples include review of the curriculum in conjunction with the Kenya Medical Training College and the Department of Obstetrics and Gynecology at the University of Nairobi. Sustainability was also addressed by support for institutions such as PSRI that serve as a resource for knowledge and training in the region. In addition the positioning of liaison officers/ NPPPs in relevant ministries aided in skills transference.

Summary of Findings

Overall the RH &R achieved the set targets in some instances and not in others as a result of facilitators on one hand and barriers on the other. Within **output 1** the innovations around repair of obstetric fistula and the training of community midwives addressed to some extent issues of access to quality services. Access to services by young people was higher in centres that were functional and linked to a health facility than in the youth empowerment centres. It is noted that the contribution of these centres were constrained by challenges outside the programme. The delays due to lengthy government procurement procedures also hampered infrastructural development of the health facilities and youth centres thereby affecting the contribution of these facilities. The high cost of camps for OF repair and the decision to mainstream OF in routine health facility surgery was a step towards sustainability.

Output 2 focused on advocacy activities that addressed change in behaviour particularly with regard to abandoning harmful socio-cultural practices. The number of IPs implementing activities contributing to this output was below the target for 2012 by only three and given that the programme cycle had been extended to 2014 this target is likely to be met. The advocacy and referral of OF clients was still ongoing based on data from MUMCOP and was likely to continue, despite challenges such as availability of surgery at health facilities on a routine basis. Uptake of FP seemed to be on the decline thereby affecting the distribution of contraceptives to women of childbearing age. In addition, facility records showed stock outs over a period of time, particularly of LAPMs. Revitalization of family planning was on course with the training of CM/CHEWs that exceeded the target by 47. This was envisaged to expand with the injection of funding from NCPD for advocacy on the repositioning of family planning.

Output 3. The target of the provision of high quality services to prevent HIV and sexually transmitted infections, especially for women, young people and other vulnerable groups was met and in some instances exceeded. Facilitating factors included GOK commitment to reduction of HIV infection, and existence of structures that adequately responded to this. The support to SWs through business training and loans was an effective strategy for influencing behavior change. Condom programming in particular benefited from UNFPA's ability to purchase these commodities directly when necessary and the GOK commitment of resources to purchase and distribute condoms. Working with strong and established partners on this output contributed to its achievement. The introduction of DICs in Kilifi under ICRH and FHOK in Nairobi expanded access to a wider range of services to the extent that the target of 75,000 people to be reached was exceeded by far. This despite the fact that not all the implementing partners addressing this output were reporting regularly and some were only operational for one year (MSK). It may also be an indication that the target may have been set too low hence the need to rationalize setting of targets.

Promising Practices

- Use of CBOs in the mobilization of OF clients and referral as well as creation of "ambassadors of hope" to mobilize clients and spread messages of safe motherhood and prevention of the occurrence of obstetric fistula was a milestone with positive beneficiary assessment.
- Training of community midwives in collaboration with MOPHS (DRH) and the increasing access to quality services at community level was also a step in the right direction. Community midwifery increases skilled attendance and should be scaled up and their contribution to overall skilled attendance well documented. This should be supported with a concerted focus on information sharing and demand creation for utilization of RH including FP services as well as addressing socio-cultural factors that influence decision making in utilization of health services
- The establishment of drop-in-centres reduced stigma and increased access to an integrated set of RH services to clients beyond the MARPs.

Lessons learnt

- Working through the government established structures is a plus as it secures ownership and works towards sustainability
- Working with well established Implementing partners produces results.
- Baseline data is critical for evidence based programming
- Concept of Model health centres has led to improved uptake of services
- Programme implementation that is embedded in Government frameworks and institutions though desirable, is greatly affected by delays that reduce programme performance.
- Prepositioning stocks in a timely manner has been key in emergencies
- Strong community linkage is key to enhancing demand creation through community strategy and use of resource persons from the community leads to sustainability.
- Integration of services and inclusion of IGA component is key to success in addressing needs of Sex Workers
- It is important to document and share working initiatives such as the contribution of community midwives to skilled attendance.
- Collaboration between UNFPA and humanitarian partners is new because RH has not traditionally been a strong aspect of humanitarian assistance. The emerging role for UNFPA in humanitarian response and working with KRCS that has ground presence in hard to reach areas has the potential to expand access to vulnerable groups.

4.3 Population and Development

4.3.1 Relevance

To what extent are the objectives of the 7th CP aligned to the objectives of MTP1 and the Vision 2030? To what extent does UNFPA support to Kenya respond to individual beneficiary requirement and to national priorities?

The 7th CP is a by-product of a series of wide and mutual consultative agreements between the government of Kenya and UNFPA signed in 1991 in furtherance of the fulfilment of the Programme of Action of the International Conference on Population and Development (ICPD), ICPD+5, other related conferences and the Millennium Development Goals (MDGs) (Sessional Paper no. 6 of 1999 on Environment and Development).

The implementation of the 7th CP satisfied a high threshold of alignment between UNDAF outcome, UNFPA Strategic Plan (2008-2011), CP output and the political and social pillars of Vision 2030 and selected national priorities outlined in the first Medium Term Plan (MTPI) 2008-2012. Further alignment was evidenced by the Government's formulation and adaption of the National Population Policy for Sustainable Development intended to align population policy, strategies and programme with MDGs and Vision 2030. Additionally, the progressive incorporation of newly emerging population issues into various development frameworks, such as the second and third Annual Progress Reports of Vision 2030 dovetailed very well with PD output 1.

The recognition given to population and population related issues of housing and urbanization in MTP I, in the 2nd Annual Progress Report (2009-2010) and in the 3rd APR (2010-2011) of Vision 2030 was unprecedented given that in the original vision document the linkage was not as explicit with reference being made only to housing and urbanization and separately to Environment Management (under the social pillar).

The planned interventions in the 7th CP were relevant and met the needs policies and priorities of a wide range of stakeholders and target groups. These included: strengthening of district planning and management units of government departments/ministries as well as technical and financial support to non-government actors to generate, access, utilize and disseminate relevant data for purposes of planning and tracking progress in support of social welfare. Relevance was further evidenced by joint programming especially in M&E and DPHK between UNFPA and other UN agencies.

In addition, relevance of UNFPA support manifested itself through technical assistance and capacity building provided by UNFPA which contributed in part to positive outcomes such as reduced gender disparities in school enrolment rates and increased transition rates. Awareness created through UNFPA support for integrating PHE resulted in part to sustained effort by the government to integrate principles of sustainable development into the country's policies and programs with a view to reversing the loss of environmental resources with the attendant direct benefits of increased forest cover.

Subsequent APRs of the Vision 2030 also provided evidence of manifestation of this relevance, with the conspicuous display of emerging population issues including migration and urbanization into the long-run development blueprint. In the framework of national/sub-national needs, the progress attained in the focal districts (as evidenced by the opinion of DDOs who have served in non-focal districts) suggested satisfaction of an important unmet need in district planning units especially (through RPCs) in terms of data capture and maintenance of relevant data-base. This support extended to tracking of MDGs at district level.

Summary of Findings

The 7th CP was well aligned to key national policy frameworks. Its interventions were relevant to a wide range of stakeholders including the government, non-governmental actors and private citizens. The high level of relevance was manifested in the progressive incorporation of emerging population issues into subsequent revisions of the APRs of Vision 2030. These notwithstanding, UNFPA's support was dogged by some operational constraints, notably the incessant division of existing districts into smaller units. For instance Nairobi West today has 3 districts, Kilifi and Naivasha have 2 apiece while the present day Migori now has seven districts. Additionally, devolution is expected to create fresh and hitherto unforeseen challenges.

4.3.2 Effectiveness

To what extent were the expected outputs of the CP achieved? To what extent were the planned geographic area and targeted groups of beneficiaries reached by UNFPA support? Are there any unintended effects of such support; whether negative or positive?

The scope of PD coverage defined immediate beneficiaries at two levels, the national and district levels. The national level coverage was focused on policy development; capacity building and data collection and analysis while the sub-national (district) focused on capacity building in Monitoring and data/information use. This focus translated into two outputs from which effectiveness can be assessed relative to specific activities as outlined here below.

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

Attendant activities to be assessed included:

- Monitoring and reporting of relevant MDG targets;
- Integration of population issues into sectoral policies and programmes;
- Integration of population variables in environmental planning and management;
- Incorporating gender equality, reproductive health and HIV/AIDS in contingency for emergencies.

Monitoring and Reporting of Relevant MDG Targets

UNFPA continued to give unqualified support to the national monitoring and evaluation system in the four focal districts by facilitating quarterly District Monitoring Visits by the District Monitoring and Evaluation Committee in the said districts and also through GOK/UNFPA joint field monitoring visits. To support and strengthen monitoring and reporting of programme performance and MDGs targets achievements, UNFPA facilitated training of all IPs in M&E and on RBM. Towards this end, UNFPA also extended support for the review of the current M&E framework and manual with a view to guiding M&E for population programmes at NCPD and this process was still on-going at the time of this evaluation.

Furthermore, UNFPA provided support for coordination mechanisms. Over the programme cycle, it supported 1 internal review meeting for RPCs, 1 outcome meeting and 8 TWG meetings on ASRH&D and POA in the regions. In addition, it supported the mid-term and now the final evaluation review. It also provided infrastructural, technical and financial support to RPCs to carry out coordination activities in their respective regions. UNFPA also extended similar support towards strengthening of the focal district's planning and management units in addition to supporting stakeholders' coordination meetings on the implementation of MDGs and ICPD POA in each of the districts.

Over the programme cycle, a number of important activities aimed at strengthening monitoring and reporting were lined up. Two GOK/UNFPA joint review meetings on ICPD and MDGs were planned and completed in July and December 2012. These meetings enabled programme review and refocusing. In addition, in the base year (2009) four officers participated in an ICPD + 15 meeting, one ICPD Beyond 2014 operational review was conducted and a draft report submitted and 88 district level officers were trained on E-promis.

UNFPA support also targeted revitalization of vital registration system in the four programme districts over the cycle. To this extent, training of registration agents on civil registration was on-going in two of the four focal districts (i.e. Migori and Kilifi) at the time of this evaluation. It is envisaged that by the end of the programme cycle, the same shall have been extended to the remaining focal districts.

Integration of Population Issues into Sectoral Policies and Programmes

UNFPA did not have an initial input into the country's long-term development blueprint (Vision 2030) which is the main national strategic document. Over the programme cycle however, intensive effort was directed at facilitating integration of population issues into national and sub-national policy and programme documents with NCPD taking centre stage in the coordination of the country's population programme.

Another important component of this activity was UNFPA's support through NCPD for the dissemination of population policy, the development of county action plans and the development of periodic reports on PD. Over the programme cycle, two MTP progress reports incorporating PD, RH and GE issues had already been produced and disseminated and a third one was being finalized and the State of Kenya and World Population report prepared and launched all as planned.

Others included publication, launch and dissemination of State of Kenya Population 2009, 2010 and 2011(the 2012 report is currently being finalized), Facts and Figures on Population and Development 2011, and the Report of Training Workshop on Integration of PHE in Development Programme and Projects of 2011 as well as a policy brief on population issues. In addition, NCPD also re-launched intensive family planning advocacy campaigns with the support of UNFPA and GOK. Besides, 7 county level sensitization forums on population policy were held and draft plans of action developed to guide implementation of the population policy at the county level. The 7th Country Programme also facilitated coordination, by NCPD of Resource Surveys and ICPD

Reviews and more importantly, the premier population advocacy platform- the annual world population day celebrations.

The National Leaders' Conference held in 2010 should be seen in this light as should the publication and dissemination of the Youth Dialogue Tool designed to address youth issues, but even more critical was the formulation and adoption in 2012 of the Population Policy for National Development. UNFPA also supported targeted advocacy through KEMEP and KEWOPA to raise the level of awareness and to inform appropriately political discourse at both the civic and parliamentary levels.

Integration of Population Variables in Environmental Planning and Management

Within the 7th CP cycle, UNFPA supported several capacity building trainings, as well as orientation and sensitization workshops on integration of Population Health and Environment in development planning. UNFPA also extended infrastructural and financial support to KEMEP and KEWOPA, with a view to enhancing advocacy campaigns and sustained dialogue among key stakeholders.

Over 120 officers from the government and other implementing partners underwent UNFPA supported training on integration, surpassing the cycle target of 100, and a training manual and set of indicators were also developed with UNFPA support over the programme cycle to further this course.

Incorporating Gender Equality, Reproductive Health and HIV/AIDS in Contingency Plans for Emergencies.

Over its cycle, the 7th Country Programme targeted equipping 40 individuals with requisite skills, and necessary assessment tools to support incorporation of gender equality, reproductive health and HIV/AIDS in contingency plans for emergencies. In addition the programme aimed at building capacity of the said individuals to conduct micro-assessment in humanitarian and emergency situations besides supporting the development of a database of populations affected by humanitarian crisis;

Effectiveness of CP Output 1

The extent to which actual effects corresponded to planned effects (output 1) was satisfactory. The level of consciousness created at the political level through the National Leaders' Conference acted to spur interest in PD issues and the recently adopted Population Policy is a direct offshoot of this. Following the conference subsequent reviews of the MTPs reveal an increasing level of integration of population issues into national planning with more attention given to emerging population issues such as migration and urbanization.

Evidence from the Annual Progress Review showed progressivity in the level and depth of coverage with subsequent editions of the report. This progressivity was replicated at the sectoral levels as well. Consequently, district development plans integrated population issues into their plans especially on youth unemployment, migration, urbanization, gender disparities and general demographic data, and environment among others.

UNFPA support also helped nurture an M&E culture at both the national and sub-national levels. This helped make reporting strong and consistent compared to the pre-funding period. In fact, 100% of respondents reported that DMECs had become much stronger and more serious than the pre UNFPA funding era. This therefore enhanced monitoring and reporting of programme performance and MDGs targets achievements.

UNFPA's efforts at integration of population variables into environmental planning and management were also felt at least at the level of political discourse. Media content analysis by KEMEP showed an inclusive number of features and stories on PD in both the print and electronic media, with much of this coming from comments, opinions, and speeches of politicians and senior government officials. What needs to be done presently is for UNFPA to identify and derive, through this existing platform, a more narrowly defined and more focused campaign on few pertinent PD topics/ issues such as family planning.

These successes notwithstanding, UNFPA support towards strengthening of the district planning and management units were not as effective as expected. Effectiveness was constrained by lack of capacity in

some cases and limited office infrastructure in other cases. Consequently, access and utilization of relevant database was impeded in 2 of the 4 focal districts. This acted to compromise efforts aimed at tracking MDG indicators. Tracking efforts were further hampered by the fact that, except for health indicators (done at district level), reporting of MDGs continued to be done at the departmental level. Besides, the targets for revitalization of vital registration system were unlikely to be attained.

Despite extensive programme support, low level of awareness still pervaded planning (national/sub) with regard to integration of PHE variables not only in the focus districts. District development plans of the said districts, although developed after the 7th CP, did not exhibit sufficient depth of understanding of the relevant linkages between planning and PHE, even though this linkage was also emphasized in the 6th CP. This was evident from the quality of reports from partners most of which captured activity rather than output level results. The net effect of this was to hamper replication in non-focal districts which jeopardized sustainability of programmes. Besides, the set of indicators developed with UNFPA support for use in monitoring the linkages between PHE at all levels were never ever put to use. UNFPA support for capacity building for the conduct of micro-census and rapid assessment surveys in humanitarian and emergency situation in relevant institutions was also not successful over the programme cycle with targets for this activity remaining largely unmet due to resource constraints.

Summary of Findings

Effectiveness of UNFPA interventions manifested itself in the progressive integration of emerging population issues into the successive annual progress reports of the Vision 2030 and in the explosion of population and environmental issues into the political discourse in the country. UNFPA support also helped make reporting strong and consistent thereby leading to enhanced monitoring and reporting of programme performance and MDGs targets achievements. However, low levels of awareness still pervaded planning at all levels with regard to integration of PHE variables. Besides, efforts at strengthening the planning units continued to be constrained by a number of factors, key among them being resources.

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

In order to determine the level of achievement of output 2, the following sub-areas were assessed:

- Support for collection, analysis and dissemination of data from 2009 Population and Housing Census;
- Providing support for conducting socio-demographic surveys;
- Supporting socio-cultural, population and demographic research;
- Developing databases for monitoring and evaluation of policies and programmes.

Support for Collection, Analysis and Dissemination of Data from 2009 Population and Housing Census

The 2009 Population and Housing Census is arguably the flagship activity of the 7th Country Programme. The census came soon after the Post-Election Violence (PEV) which had elements of ethnic profiling. This made many stakeholders quite uncomfortable with the census. Consequently UNFPA came in to support advocacy to shore up support for the census in addition to supporting data collection, analysis and dissemination and also the post-enumeration survey.

UNFPA also spearheaded mobilization of resources from other development partners to support compilation of census reports, besides supporting capacity building of KNBS staff on RBM and other follow-up trainings. Analysis of census report also benefited immensely from institutions directly supported by UNFPA in terms of capacity building such as PSRI, NCPD and PAK.

Support for Conducting Socio-Demographic Survey

UNFPA was perceived as a critical direct and indirect partner in the strengthening of the country's statistical system for its role in providing both financial and technical support to KNBS but also in the role of mobilizing and coordinating other development partner support for the Bureau. In particular UNFPA supported trainings such as Regional CSPRO training, PES training at the US Census Bureau as well as two RBM programmes over

the programme cycle.. Additionally, UNFPA supported the conduct of Kenya Demographic and Health Survey, whose report was finalized, launched and disseminated over the programme cycle as well as KSPA and KAIS reports. It also supported advocacy and dissemination of socio-demographic survey results by strengthening its engagement with KEMEP and KEWOPA.

Support for Socio-Cultural, Population and Demographic Research

In the 7th Country Programme, UNFPA's intervention in socio-cultural demographic research was intended to provide support for programme planning and implementation as well as policy dialogues in programme areas but no resources were channeled towards this activity in the programme cycle.

Support for the Development of Database for Monitoring and Evaluation of Policies and Programmes

Over the programme cycle, UNFPA extended both financial and technical support towards the recruitment of a data processing expert to develop and update IMIS. In addition, it supported the training of departmental heads and officers from key IPs in focal districts all with a view to facilitating access and use of IMIS, besides supporting the more robust and effective NGOs' database hosted at NCPD.

Effectiveness of CP Output 2

The extent to which actual effects corresponded to planned effects (output 2) was highly satisfactory. The CP Output 2 was a niche output for UNFPA's country programme and the 2009 Population and Housing Census its flagship activity. Without UNFPA's support, it would not have been possible to conduct the census with the same level of timeliness and success and at the same depth of quality given that support was not only financial, but also technical. UNFPA's support for capacity building fed directly into improving the quality of management, analysis and the reporting of census results.

Arising from the foregoing 100% compliance to the census dissemination schedule was achieved over the programme cycle with 12 analytical reports, 4 basic reports, 1 PES draft report, and 1 census atlas being developed. The timeliness with which the basic reports were produced and the soundness and depth with which the analysis was done, culminated in the UN Award for Publicity for Kenya.

These successes also extended to the conduct of Kenya Demographic and Health Survey, KSPA and KAIS whose reports were finalized, launched and disseminated over the programme cycle. KSPA report today provides baseline information on the health service provision and utilization to the citizens, policy makers and MoH officials for use in planning for improved healthcare provision in the country.

The partnership with KEWOPA and KEMEP in particular served a very useful purpose, particularly in creating awareness on population and development issues. Strengthening these partnerships increased the effectiveness of UNFPA support particularly for advocacy and dissemination of socio-demographic survey results.

All these achievements met the target set for the programme cycle but the effectiveness of such intervention would have been boosted by additional UNFPA support for further analysis of select modules of selected socio-demographic reports, especially KDHS.

Evidence suggested that no socio-cultural demographic survey (s) was conducted over the programme cycle as planned due to limited resources. Policy dialogue however, benefited immensely from partners' participation in international research networks as evidenced by the presentation of 2 papers in UAPS conference against a target of 3 and the presentation of 24 papers in the National Leaders' Conference held in 2010.

The National Leaders Conference played a crucial role in raising the profile of population issues and its interlinkages with development in the political discourse of the country. The attribution effect can only be expected to cascade to sectoral planning as well as to the broad national planning documents. A follow-up conference would have enhanced this profile further. It is notable that a target of six such conferences over the programme cycle was overly ambitious.. Given the time it takes to successfully organize and host such a conference, effectiveness would actually have been

compromised even if only half of this target was met. The issues discussed in the conference formed a basis for the development of the recently adapted Population Policy for National Development.

Over the programme cycle, 12 datasets were uploaded into IMIS, among them the 1989 and 1999 Kenya Population and Housing Censuses, Demographic and Health Surveys for the period 1989, 1993, 1998 and 2008/2009 among others. This helped increase access to quality vital data for planning purposes in addition to facilitating seamless dissemination of the same.

Additonally, 40 departmental heads and officers from key IPs in focal districts were trained to facilitate access and use of IMIS and UNFPA support ensured continuous updating of IMIS over the programme cycle. These notwithstanding, low levels of utilization compromised effectiveness. Since 2011, technical problems with KNBS server made online accessibility of IMIS impossible as did the lack of or limited internet connectivity in almost all the focal districts Evidence from IPs painted a largely unused, un-updated and ineffective system. Despite training, lack of capacity in operating IMIS was widely reported amongst IPs.

UNFPA's support for the NGOs database helped improve coordination, monitoring and evaluation of the contribution of NGOs to population and development discourse, in addition to helping with profiling of the same. Database sharing allowed stakeholders to access and utilize data generated by institutions with comparative advantage in disparate but related areas. To this extent, effectiveness would have been boosted by collaboration between UNFPA and other UN agencies to develop and manage a common database such as the stillborn Kenya Human Development Information Management Network.

Monitoring and evaluation policies and programmes in the country would also be immensely facilitated with the existence of an up-to date database on populations affected by humanitarian crisis particularly against a background of the effect of PEV spilling over into the programme cycle and in view of the displacement resulting from evictions in forestlands arising directly from progressively increasing environmental awareness in the country. No such database was found at any of the IPs.

Summary of Findings

The single most important contribution of UNFPA in PD was the support it continued to give to the national statistical system either directly or indirectly. This support acted to develop unique and critical skills and capacities and to strengthen data collection and analysis functions thereby improving greatly the quality of data and by extension, the planning process in the country. Strengthening advocacy campaigns and awareness creation remained an important mechanism for driving policy dialogue on PD issues at all levels hence the need for closer engagement with KEWOPA and KEMEP.

4.3.3 CP Efficiency

To what extent were activities and resources managed in such a manner as to ensure delivery of quality outputs in relation to resources used?

Efficiency in the use of resources and management of activities in the 7th CP were partly attributable to UNFPA and partly to other actors. Overall, for those activities and resources where UNFPA had direct control, the efficiency of resource management and utilization was deemed satisfactory. Under PD, eight activities were lined up for implementation in the programme cycle. Whereas certain components of some of these activities were only partially implemented, 25% of the activities had not been implemented at all. For instance under "Monitoring and reporting of relevant MDG targets", a number of MTP progress reports incorporating PD, RH and GE were generated but none of the planned GOK/UNFPA joint review meetings took place. Deviations from planned activities were also observed in many instances.

Reporting appropriately on results is an important yardstick for efficient programme implementation. UNFPA's capacity building on RBM imparted a commendable culture of reporting. Evidence however showed that most partners still reported at activity instead of output level. Whereas such reporting anomalies could be attributed to ambiguous indicators and limited capacity caused by high turnover in GoK offices, this eroded efficiency gains in programme implementation considerably.

Disbursement of CP funds from the treasury was variously cited as a major source of inefficiency in the programme cycle. The 6th CP end-line review and the mid-term review for the 7th CP also picked out this particular bottleneck. Several factors were responsible for this delay; key among them being: bureaucracy in parent ministries, limited understanding of government processes by IPs, limited sharing of information between project officers and the rest of the ministry staff (finance department) among others. Resultant delays created barriers at various implementation stages leading to low realization of targets.

Factors outside the sphere of control of UNFPA such as limited capacity at KNBS which delayed considerably the finalization of PES report and attrition of key staff in the population directorate also acted to reduce the level of efficiency of programme implementation. This was compounded by limited monitoring capacity of the country office.

Estimating Budgetary Efficiency for Country Office

The efficiency of country programme disbursements was estimated using planned and actual expenditure. An analysis was also done on the efficiency of allocations of CO disbursements using a mathematical programming method called Data Envelopment Analysis (DEA), which provides robust metrics and more rigorous analysis than those obtained from the use of normal ratios. DEA compares different but similar Decision Making Units (DMU) in the way they create outputs from inputs by constructing a best practice frontier. It then evaluates each DMU in relation to the benchmark. Efficiency is computed and given by the ratio output/input situation for each DMU (Appendix 3).

Efficiency was estimated in two stages: In the first stage, efficiency of Population and Development programme components across different years was evaluated. In the second stage, the efficiency of the PD programme component in the 7th CP relative to the 6th CP over different years was then appraised.

Efficiency of the 7th Country Programme

The 7th CP Efficiency Analysis covered the period 2009-2012 over which an assessment was conducted on the relationship between mobilised and expended resources. Results are reported in Table 13, where the figure 1 is interpreted as the most efficient level.

Table 13: Efficiency across the 7th CP Years of Implementation

Years of Implementation	PD Calculated Efficiency
2009	0.970
2010	0.789
2011	1.000
2012	0.905
Mean	**0.916**

Based on the results in Table 13, no clear trend of disbursement efficiency was discernible. The average level of disbursement efficiency for PD programmes in the first four years of the programme cycle (2009-2012) stood at 0.916. At programme inception, disbursement efficiency was higher than average at 0.970, but declined considerably in 2010 to below average levels of 0.789. However, it then peaked again to above average levels in the subsequent years. The year 2011 was, therefore, the most efficient at a maximum of 1.000.

Table 14: Efficiency Analysis using Ratio of Expenditure to Mobilised Resources

Component	Implementation Ratio				Mean	Standard Deviation
	2009	2010	2011	2012		
PD	0.9307	0.7568	0.9594	1.0301	0.9193	0.1161

The ratio analysis method (Expenditure/Mobilised) corroborated estimates obtained through DEA. Table 14 shows that disbursement efficiency was highest in 2011 followed closely by 2009 and 2012 with all the three periods registering above average levels of efficiency. The year 2010, however, recorded below average levels at 0.7568. Although all the four levels are close to the mean ratio given the small standard deviation of 0.1161, year 2010 contributed the most to lowering the mean level of efficiency. For all the programme years, however, the implementation rates fell within the statistically acceptable bounds. The overall disbursement efficiency levels for PD in the 7th Country Programme were, therefore, above average hence acceptable.

Efficiency Comparison between 6th and 7th CP

The relative efficiency of the 7th Country Programme was compared to that of the 6th Country Programme based on the years of programme implementation. The comparison, however, focused on the first four years of CP implementation because available data for the 7th CP was for the first four years (2009-2012). For the 6th CP, this analysis, therefore, considered the period 2004-2007.

Table 15: Efficiency Comparison for the 6th and 7th CPs in their First Four Years of Implementation

Years of Implementation	PD Disbursement Efficiency		
	6th CP	7th CP	Mean
1st year (2004 vs. 2009)	1.000	0.977	0.988
2nd year (2005 vs. 2010)	1.000	0.793	0.897
3rd year (2006 vs. 2011)	1.000	0.993	0.996
4th year (2007 vs. 2012)	1.000	0.865	0.932

Based on results in Table 15, for each of the four programme years under comparison, the 6th country Programme registered the highest disbursement efficiency levels of 1.000 with the 7th CP registering mixed results. In the first (2004/2009) and third programme years (2006/2011) however, the efficiency gap was almost insignificant. Although both programme cycles registered acceptable levels of efficiency, on average, however, the 6th CP was relatively more efficient than the 7th CP in the first four programme years.

Summary of Findings

Efficiency with which resources were converted into output was determined by both internal and external factors. This notwithstanding, some actions taken by UNFPA enhanced efficiency gains in the programme, notably provision of support for capacity building and other levels of training, provision of infrastructural and technical assistance and securing of support from other development agencies to provide technical and financial assistance in key focus areas such as KPHC activities with a view to filling capacity gaps at KNBS particularly in respect of the 2008/9 KPHC activities.

Whereas operational inefficiency levels may have been high due to internally generated failures such as poor reporting, weak indicator design processes and inability to meet some set targets, a number of these failures were also caused by bottlenecks outside the sphere of control of UNFPA such as capacity issues in government or partners. On average however, efficiency of disbursements was acceptable and budgetary deviations from planned expenditure fell on average within the acceptable statistical boundaries which suggested a strong target setting system in the CO. Much however remains to be done to increase efficiency of resource use and activities.

4.3.4 Sustainability

To what extent are the benefits likely to continue beyond programme termination? Has UNFPA been able to support its partners and the beneficiaries in developing capacities, mechanisms to ensure durability of efforts? Were the activities, outputs designed taking into account a reasonable handover to local partners?

Certain aspects of the 7th CP were supportive of sustainability while others were not. The consultative, all inclusive and participatory approach adapted at the program design stage entrenched sustainability by creating a sense of ownership of the programme from the wide array of governmental and non-governmental stakeholders involved. The involvement of the same stakeholders at every stage of the programme also ensured sustained interest and continuous creation of awareness on PD issues. The progressive inclusion of PD issues in the Vision 2030 Annual Review Reports was perhaps the clearest indication of this sustained interest.

Sustainability was also enhanced by the continuous support to IPs that played an important role in the knowledge industry, particularly KNBS and PSRI. The impact of any capacity support to these institutions were likely to have a huge positive externality and dissemination effect that went beyond the confines of CPE through provision of high quality data and evidence based research and outreach.

The greatest threat to sustainability of UNFPA's programmes was however, the total absence of an inbuilt hand-over mechanism or long-term time –out strategy or schedule. This was further compounded by the absence of a long-term institutional capacity development and tracking strategy to ensure continuity or institutional memory succession in the IPs. This omission manifested itself in ever present capacity gaps especially in government IPs caused by high staff turnover and in some cases attrition.

Limited financial support to some IPs for example DDOs made it difficult to assess the full or optimal impact of such support. Consequently it was not possible to project up-scaling or replication effects for sustainability purposes. Though highly debatable, 54% of respondents sampled believed the programme was not sustainable post UNFPA.

Summary of Findings

Design of 7th CP did not take into account the possibility of eventual hand-over as no systems or structures were put in place to support handover. Neither was a time-out schedule and long-term capacity development strategy developed. The consultative and participatory approach to programme design and implementation adopted by CO however helped secure ownership of IPs in the programme thereby enhancing programme sustainability. All factors considered, the level of programme sustainability was however low as evidenced by lack of strategic planning on transfer of UNFPA programme to government.

4.4 Gender Equality

4.4.1 Relevance

To what extent is the GE component of the 7th CP- 2009-2013, consistent with the needs of the: i) country priority needs; ii) partners/ beneficiaries; iii) UNFPA's policies and strategies and iv) International agendas, plans, strategies, frameworks and policies regarding gender equality and human rights?

Kenya is a signatory to several gender related International Conventions and Treaties. These include; Protocol to the African Charter on Human and People's Rights Adopted at the African Union (AU) Summit (2003), Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), Commission on the Status of Women and African Platform of Action, and the Beijing Platform of Action. Kenya is committed to the attainment of Millennium Development Goals which are consistent with the twelve critical areas of concern for the Beijing Platform of Action, the resolution of African Union Summit on employment creation and poverty alleviation, Convention on the Rights of the Child (CRC), United Nations declaration on Violence Against Women (VAW) 1993 and the International Conference on Population and Development (ICPD).

Gender equality and the empowerment of women are highlighted as a key national priority in a number of

policies, laws, frameworks and strategies. The 7th GOK /UNFPA gender equality component is aligned to the following key strategic documents: the Vision 2030 and its Medium Term Plan (2008-2012), the National Gender and Development Policy (2000) and its Action Plan (2008-2013), Sessional Paper No. 2 of May 2006 on Gender Equality and Development, Ministry of Gender and Social Development (MOGSD) Strategic Plan (2008-2012), the National Commission on Gender and Development (NCGD) Strategic Plan (2008-2012), National Framework towards Response and Prevention of GBV (2009) and Agenda item No. 4 of National Accord and Reconciliation Agreement (NARA) and the constitution that emphasizes the rights and freedoms of persons (2010) .

UNFPA places a premium on coalition-building and strong partnerships under the UN framework of Delivering as One which ensured that each UN agency's efforts and outputs complemented that of others in furthering a gender-equality agenda. At the global level, UNFPA was an active member of United Nations inter-agency networks and groups collaborating on gender mainstreaming, violence against women (VAW), the prevention of HIV and AIDS, and adolescent girls.

At the national level, the GOK-UN Joint Programme on Gender Equality and Women's Empowerment (JP GEWE) represented an important framework for UN's coherence and cohesiveness in delivering on issues related to gender equality and women's empowerment in Kenya. It brought together 14 UN agencies[6], including UNFPA, under one programmatic framework, to underscore UN's commitment to 'Delivering as One'. The JP GEWE was fully aligned to the national priorities for the advancement of gender equality and women's empowerment in Kenya, the foundations of which are described in Kenya's development blueprint of Vision 2030 and its Medium Term Plan (2008-1012), the National Gender and Development Policy (2000) and its Action Plan (2008-2012), Sessional Paper No.2 of May 2006 on Gender Equality and Development, the NCGD (now National Gender and Equality Commission) Strategic Plan (2008-2012), the MoGCSD (now Ministry of Gender and Social Development - MOGSD) Strategic Plan (2008-2012), National Framework of GBV (2009), Agenda 4 of the National Accord and Reconciliation Agreement, and the Millennium Development Goals.

The Joint Programme aimed at contributing to national objectives as outlined in the above documents within five inter-related strategic priority areas, namely: gender mainstreaming(UNWOMEN), Gender-Based Violence(UNFPA), gender and Governance(UNDP), Economic Empowerment(ILO), UN Coordination and 'Delivering as One'(UNWOMEN). Within the UNCT, UN Women was the official coordinating agency for this programme, while the UN Joint Programme Working Group on Gender (UNPWG) consisting of representatives from all agencies working in this area developed and implemented the programme.

4.4.2 Effectiveness

To what extent were the expected outputs of the CP achieved? To what extent were the planned geographic area and targeted groups of beneficiaries reached by UNFPA support? Are there any unintended effects of such support; whether negative or positive?

In assessing the effectiveness of the gender equality component of the 7th GOK/UNFPA Country Programme (CP), the degree of achievement of outputs, the extent to which the outputs contributed to the achievement of the outcomes and the unintended effects of the interventions implemented were analyzed. The scope of GE component was defined across national and sub-national levels. Both the national and sub-national level strategies were focused on advocacy and policy dialogue/consensus building, capacity building and networking, community mobilization and participation and the creation of partnerships to address gender related issues, including GBV; and the positioning of gender equality on the national agenda. This focus translated into three outputs with specific activities from which effectiveness was assessed as outlined below.

Output 1: Increased access to accurate & appropriate information & services on sexual & GBV including emergency and post emergency situations

6 UN WOMEN, UNFPA, UNOCHA, UNICEF, ILO, UNHABITAT, UNODC, UNIDO, UNAIDS, UNESCO, IOM, UNEP and WHO

The key strategies that were applied to achieve this output included:

- Capacity building for implementation of gender responsive policies and programmes,
- Advocacy and policy dialogue for implementation of gender responsive policies and strategies
- Networking and partnerships with key stakeholders including UN Agencies, Government, Media, and CSOs including FBOs, and
- Building and using a knowledge base to address specific gaps in SGBV programming in selected districts including in emergency situations. Support to the promotion of gender equality through advocacy and community involvement including participation of males.

The major activities, indicators, baseline, targets and achievements for this output are reported in appendix 8

Support to Promotion of Gender Equality through Advocacy and Community Involvement Including Participation of Males

The programme supported implementing partners (IPs) to build capacity of community leaders and various groups (men, youth, and women) to enable them to create awareness on issues related to gender equality, including sexual and gender-based violence (SGBV) in the four focus districts. Both national and community networks comprising of various leaders, local administration, watch groups, GBV working groups and court users' committees were strengthened to advocate against gender inequalities, including SGBV. Implementing partners (IPs) developed culturally sensitive behavior change communication strategies on SGBV and supported the establishment of watch groups, networks and information centers at the community level. The strategies used for effectiveness towards achieving this sub-output included: community forums, cycling campaigns, football matches, wedding ceremonies and other school based activities. A total of four community networks have were established in the focus district, chaired and coordinated by the District Gender and Social Development Officer (DGSDO/ MOGSD).

The formation of GBV/FGM working groups and community networks and the continued investment in skills and capacity building towards gender equality including GBV, FGM and HIV/AIDS, by the programme resulted into the formation of sub-committees at the grassroots level thereby creating a positive 'spill-over' effect. For instance, in Naivasha and Nairobi West Districts, a total of 279 young men and women were trained as *"Ambassadors of Change".* The young women and men acted as role models educating communities and creating awareness on GBV prevention and response. In addition, a Young Women Leadership Training was conducted in two districts (Naivasha and Nairobi West), where 158 young women received training and further used the skills and knowledge gained to establish a community-based organization, *Women Empowerment Networking Group,* a registered entity handling GBV cases, three of which were taken up by the formal justice system.

The programme supported the establishment of a system for GBV data collection through incident recorder and the setting up of a website *www.gbvkenya.org,* coordinated by the National Gender and Equality Commission (NGEC). The Gender Based Violence Information Management System (GBVIMS) and website were specific to GBV prevention and response in Kenya. The target was to have a web-based database of GBV survivors disaggregated by sex in place. This was piloted in nine hospitals, including the Naivasha District Hospital, Nairobi West District Hospital, Kilifi District Hospital and Migori District Hospital. The pilot also covered Thika District Hospital, Nakuru Provincial General Hospital, Kitale District Hospital, Machakos District Hospital and Kenyatta National Hospital. The implementation status in the focus districts is indicated in Table 16.

Table 16: GBVIMS Implementation Status in the Four Focus Districts

	FACILITY	STATUS
1.	Naivasha District Hospital	GBVIMS Integrated into the Hospital Management Information System in 2010. The trained personnel were transferred from the facility in April 2012. Further the machines donated were stolen in July 2012 halting the continuous data collection.
2.	Migori district Hospital	GBVIMS Integrated into the Hospital Management Information System 2010. Due to a system upgrade carried out in 2011, the data was not being collected but was activated after retraining in July 2012.Need for biennial visits to ensure data is being collected accurately.
3.	Kilifi District Hospital	Computing equipment donated. Training for 25 health workers conducted
4.	Nairobi West District	Computing equipment donated. Need to train staff on GBVIMS data capture and entry

Evidence from the field indicated that its full operationalization faced various challenges which affected its effective roll-out. The challenges range from lack of a functional integrated hospital management information system (HMIS) to a high turn-over and / or re-deployment of staff already trained in GBV data management. Effective implementation of the GBVIMS required massive technical and financial support with good working mechanisms between the Ministry of Public Health and Sanitation (MOPHS) and the Division of Reproductive Health (DRH), Ministry of Medical Services (MOMS) and the Ministry of Planning/ Monitoring and Evaluation Directorate (MOP/MED).

Lobby for the Enactment of Gender Responsive Legislation

The programme supported select agencies and partners to lobby parliamentarians and other interest groups for the enactment of the Prohibition of the FGM Act in line with government obligations under international and regional human rights instruments. The key strategy used to achieve this output was advocacy and policy dialogue. As a result of advocacy forums with members of parliament, the FGM Bill drafted in 2010 and introduced in parliament for debate, was passed in parliament in record time in 2011. This was consequently signed into law. In addition, the programme supported 4 forums for parliamentary committees to lobby for the enactment of the Family Bills and to sensitize them on international human rights instruments.

The Ministry of Gender and Social Development (MOGSD), the National Gender and Equality Commission (NGEC), FIDA Kenya and KEWOPA conducted a series of meetings to lobby for support and commitment for the Family Bills. Educational forums were organized in 22 constituencies where accurate and appropriate information and services on GBV and dialogues on how to harmonize these draft laws with the new constitution were discussed. The programme supported six parliamentary committees on gender responsive legislation: the Equal Opportunities Committee; the Social welfare and Labor committee, Health Committee, Education, Children's Caucus, Committee on Justice and Legal Affairs and the Liaison and Parliamentary Caucus for Members of Parliament from Pastoralist communities.

Acquiring Parliamentarians' support for gender responsive legislation that addressed reproductive health and harmful cultural practices was an effective approach in the enactment of gender related laws. This was demonstrated in the enactment of the Prohibition of FGM Bill, 2010 where male parliamentarians' involvement played a crucial role. This translated into increased support by parliamentarians on the enactment of gender related legislation to address issues of sexual and gender based violence directly and indirectly. This is evidence that political leadership and goodwill are crucial components towards addressing gender equality issues such as GBV, FGM and reproductive health.

Sensitize Community Leaders

The programme supported implementing partners to engage with District Gender and Social Development Committees and community leaders (chiefs, women group leaders, youth group leaders, religious leaders, etc.) to enhance their knowledge on women's rights and GBV and mobilized them to effectively prevent, respond and manage SGBV in selected districts. To achieve this, advocacy and policy dialogue strategy was deployed. Advocacy forums for 2,200 community leaders on SGBV were held in the focus districts. The sensitization of community leaders enabled the resolution of several cases for survivors in addition to enabling the restoration of justice and peace in communities. For instance, through the sensitization of community leaders, a total of 28 GBV committees were established, ten cases of child abuse and 15 cases of GBV were reported to the Chief's Office and referred to the hospital and to the police for arrest and further action. Dialogue forums were held with the Council of Elders from the Meru, Kisii, and Kuria, Pokot and Il Chamus and Tana River communities who were sensitized on the effects of FGM on economic development, education and health. As a result, the Council of Elders made public declarations against FGM.

Enlisting the Support and Participation of Faith-Based Organizations in Promoting Gender Equality

The programme supported efforts towards building the capacity of selected Faith-Based Organizations (FBOs) and other culturally sensitive institutions, such as the Council of Elders, SUPKEM, etc., to create awareness on issues related to gender equality as well as sexual and gender based violence, including FGM. In addition, FBO networks and partnerships were supported to develop appropriate IEC and BCC strategies. The support to faith-based organizations was also used as a key initiative in creating awareness and mobilizing support towards the gender draft bills and policies. These engagements resulted in public statements endorsing the legislative processes as well as reducing the negative sentiments towards gender equality. Further, with support from the programme, Women Empowerment Link (WEL) engaged a total of 30 religious leaders and FBOs in Naivasha. The religious leaders were sensitized on Alternative Rites of Passage (ARP) for both girls and boys. The National Gender and Equality Commission with support from the programme, engaged various religious leaders who included Christ Is the Answer Ministries (CITAM), Presbyterian Church of East Africa (PCEA), Kenya Assemblies of God (KAG), Seventh Day Adventist (SDA) and Supreme Council of Kenya Muslims (SUPKEM) in issues related to gender equality.

Providing Supportive Services to Survivors of GBV

The programme supported implementing partners in creating awareness on GBV prevention and response by linking them to referral centers and coordinating activities towards prevention and response to GBV, especially at the community level in the four focus districts. The key strategy applied was capacity building of selected implementing partners to enable them to support service providers in scaling up provision of GBV services in selected health facilities. The National Gender and Equality Commission with support from the programme conducted a nationwide mapping of the existing SGBV service in Kenya. The mapping exercise, the first of its kind, identified existing GBV service delivery response in Nairobi, Rift Valley, Nyanza and the Coast Provinces. It explored previous and current government efforts towards the provision of GBV services and how non-state actors complimented government in offering GBV service.

In addition, the mapping identified existing gaps in GBV service delivery within the health, legal/justice, security, medical and psychosocial support services in Kenya. The report on the mapping of SGBV services provided crucial information on the status of service providers who were also easily identifiable thus improving the coordination and partnerships in the focal districts. The comprehensive service package on GBV was put in place, and included psychosocial and counseling services, justice delivery and legal advice. Policy briefs on the mapping of GBV services in Kenya were developed and mapping conducted in the four focus districts of the programme.

In addition, the programme supported an assessment of institutional challenges faced by law enforcement agents in enforcing justice to survivors of GBV and conducted a baseline survey on GBV in four focus districts. The capacity of 1,400 law enforcement agents was strengthened and capacities to handle SGBV cases enhanced. Policy briefs on GBV Prevention and

Response were also shared with relevant stakeholders. A total of 14 networks' capacities were strengthened on the provision of protective services and social safety nets to reduce GBV in select districts. The Standard Operating Procedures (SOPs) for clinical management of Sexual Violence was also developed in collaboration with the Ministry of Public Health and Sanitation/Division of Reproductive Health (MOPHS/DRH) and was being reviewed at the time of this evaluation.

In response to marginalized populations and humanitarian crisis, the programme supported efforts towards humanitarian response in the areas of capacity building and prepositioning of stocks for response. Towards this end, capacity was enhanced in the area of RH in emergencies, psychosocial and clinical management and also in the provision of initial support to disaster victims, with dignity kits. Humanitarian response units were established and their training supported in SRH/SGBV/HIV prevention in the 4 focal districts. Training was also provided in Disaster Management through skills transfer, and through provision of integrated training focusing on prevention, preparedness and response to various disasters. With support from UNFPA, reproductive health promotional supplies were provided to communities exposed to natural and man-made disasters. Additional support went towards integrated community outreach programmes through awareness creation sessions on SRH and setting up of a 'One Stop Shop' offering various services to young women of reproductive age, the youth, women and men in the affected areas.

Strengthening the Capacity of Institutions, such as the National Gender Machinery, Police and Judicial System for the Implementation and Enforcement of Gender Responsive Laws and Policies

The programme in collaboration with selected implementing partners strengthened various stakeholder capacities in the implementation of Sexual Offences Act, the Action Plan on the National Policy on Gender and Development and related policies. The programme built the capacities of key national gender machineries including the Ministry of Gender and Social Development (MOGSD) which was supported to develop tools for the operationalization of the Monitoring and Evaluation (M&E) Framework developed in 2009. A total of 300 Gender Officers from line ministries and parastatals were also trained on gender mainstreaming and as a result, the trained officers established gender committees in their respective ministries and parastatals.

UNFPA also supported the establishment of the National Gender and Equality Commission (NGEC) and built its capacity to coordinate and oversee implementation of GBV Prevention and Response Programme. As a result, GBV working groups were established in the focus districts to collaborate and link the implementing partners working in the GBV programme. The working groups were coordinated at the district level by the Ministry of Gender, Children and Social Development (MOSGD), chaired by the District Gender and Social Development Officers in the focus districts. In addition, three NPPPs were recruited and stationed at the NGEC to upscale GBV coordination activities, GBVIMS and Gender Responsive Budgeting (GRB) projects.

In order to provide national direction, collaboration between government, development partners and CSOs in Kenya, UNFPA continued to support the efforts of NGEC in tandem with Vision 2030, whose mandate included 'coordination and policy advice' on gender related issues. The NGEC was therefore a great beneficiary of the collaboration that existed among the gender component partners. This was particularly in the area of sexual and gender based violence, which was further enhanced by the already existing structures within the Ministry of Gender and Social Development (MOGSD) at the district and national levels.

Supporting Protective Services or Social Safety Nets to Reduce GBV

The programme supported the Ministry of Gender and Social Development and various non-governmental organizations through educational forums on gender based violence prevention and response, and networking with various stakeholders in order for them to address cases of gender based violence within their communities and institutions. The National Gender and Equality Commission engaged in the mapping of Gender Based Violence Service provision in Kenya in order to advocate for up scaling of multi-sectoral prevention and response to Gender Based Violence at the community level. The mapping report was finalized. A policy brief was also developed and disseminated among key stakeholders. The National Gender and

Equality Commission also developed a National Training curricular on SGBV which was disseminated.

The developed training curricular helped in the standardization of training in SGBV prevention and response. While the government provided mainly protective, medical and legal services, non-state actors played a major role in providing awareness, legal and security support that included provision of PEP and Emergency Contraceptives, fee waiver to the cost of P3 and PRC forms and prosecution of perpetrators. At the national level, the Sexual Offences Act provided guidance in prosecution of perpetrators. At the district level, including the 4 focus districts, results indicated that selected community based organizations mainly provided para-legal and referral services, as well as shelter, clothing and food to GBV survivors. The programme supported the establishment of gender desks in police stations/chiefs' camps in the focus districts.

Several challenges hampered the effective provision of GBV services. For instance, in the medical sector, there was an inadequate number of medical specialists/professionals with skills to manage GBV, inadequate funding to cover GBV services resulting in limited medical supplies and equipment, such as PEP supplies and laboratory/forensic equipment. The main legal services offered were legal counseling (65%), legal advice (14%), follow-up (11%) and referral (1%)[7].

Training in post-rape care was very low especially at the community level, resulting in inadequate capacity to deal with survivors. The prevention, low awareness on post rape management at community level, poor follow-up mechanisms and lack of frameworks to deal with survivor protection, compounded with cultural beliefs which seemed to reinforce acceptance, tolerance rationalization, and silence about SGBV issues, further complicated the prevention, response and management of SGBV cases.

This calls for strengthening of referral systems, especially those relating to counseling and post 'violation' medical, psychosocial and legal support, access to justice and safe spaces for the survivors of GBV by getting all actors to engage in constructive dialogue. Increased funding and technical support, especially in DNA and forensic collection/testing of evidence, enhanced training and increased counseling is necessary to ensure meaningful support. In addition, follow-up mechanisms of survivors, clinical, psychosocial and legal, as well as lack of structured social safety nets still posed a great challenge to dealing with GBV. The involvement of a wide cross-section of community stakeholders in handling issues of GBV is therefore recommended.

Mainstreaming Women's Rights and Gender Equality into National Legislation, Policies, Programmes and Budgets

The Ministry of Gender and Social Development (MOGSD) produced the 2nd Bi-Annual Report 2010-2011 on the implementation of 30% Affirmative Action for women in recruitment and promotion in public service. The report analysed data collected from 40 ministries, out of the 42. In favour of this activity, a total of 100 gender officers from line ministries were trained in gender mainstreaming.

The National Gender and Equality Commission developed the National Gender-Responsive Budgeting Guidelines with the support of the programme. The guidelines were consequently used to assist in mainstreaming gender considerations, within the Ministry of Finance and that of Planning. These guidelines further provided a road map to different state agencies on how to integrate gender-responsive principles in financial and resource allocation and deployment decisions and activities thereby facilitating the implementation of redistributive measures to prevent or alleviate prejudicial allocation of resources, or the likelihood of such prejudice on either sex to reduce existing disparities between males and females.

In addition, the programme supported two NPPPs, at the National AIDS Coordinating Council (NACC). The presence of the NPPPs at NACC ensured that issues and gaps on gender were mainstreamed in resource mobilization, policy and strategy development, programme implementation and M & E. This was reflected in the outputs, outcomes and impacts of KNASP 2009/10 – 2012/13, the successful Global Fund Round 10 proposal for Kenya and call for proposals Round 4 and Round 5 for World Bank funded TOWA Project. In addition, the government acknowledged the need to

7 Mapping of Sexual and Gender Based Violence Services in Kenya, National Commission on Gender and Development (now National Gender and Equality Commission), August, 2010.

fund gender mainstreaming activities in the national response to HIV as a result of which financial support increased from 0 to Ksh. 3.3m for the financial year 2011/12. NACC was also able to reach 80 organizations that were trained in gender mainstreaming.

Output 2: Enhanced institutional mechanisms to reduce & respond to GBV & discrimination/ particularly among marginalized populations & during humanitarian crisis

The key strategies applied to achieve this output included capacity building for selected implementing partners, such as those in the judicial system, to enable them to enforce gender laws and implement gender policies; and advocacy and policy dialogue for implementation of gender responsive policies and strategies.

The output was achieved through implementation of the following major activities that are summarized in appendix 9.

- Providing supportive services to survivors of GBV
- Strengthening the capacity of institutions, such as the national gender machinery, police and judicial system for the implementation and enforcement of gender responsive laws and policies
- Supporting protective services or social safety nets to reduce GBV
- Mainstreaming women's rights and gender equality into national legislation, policies, programmes and budgets

The major activities, indicators, baseline, targets and achievements for this output are reported in appendix 9.

Output 3: Improved advocacy for women & adolescent girls' reproductive rights, male participation in RH & elimination of harmful practices, particularly FGM.

In the 7th Country Programme, Output 3 of the gender equality component was implemented within the GOK/UNFPA/UNICEF Joint Programme initiative on Accelerating Abandonment of Female Genital Mutilation (FGM) initiated in 2008. Kenya was among the 15 countries implementing activities within this programme. Since its inception, the programme played a catalytic role in galvanizing support from parliamentarians, media, religious leaders and communities.

To achieve this output, the Joint Programme used a common approach, driven by their commitment towards total abandonment of FGM globally and in response to the former Secretary General's call on ending violence against women and girls. Both agencies brought together expertise in different areas. UNICEF having expertise in the area of social change led in positive social transformation and in supporting community dialogue and public pledges as well as building capacity in this area. UNFPA as an expert in Sexual and Reproductive Health supported integration of FGM in Reproductive Health and community engagement. UNFPA and UNICEF with expertise in working with religious organizations to protect the rights of women and children brought that aspect into the programme. Thus, the two agencies created synergy in accelerating abandonment of FGM while at the same time acting as catalysts through partnership building at country level to ensure a critical mass of people support the abandonment of FGM.

To determine the extent to which output 3 was achieved, the following specific interventions were assessed:

- Supporting activities aimed at enactment of laws that address harmful practices, particularly FGM and early marriages:
- Scaling up sensitization of community leaders on the need to abandon FGM and early marriage
- Supporting alternative rites of passage and appropriate safety nets in selected districts
- Promoting gender-friendly socio-cultural environments through media campaigns

The major activities, indicators, baseline, targets and achievements are reported l appendix 10.

The programme supported an FGM Baseline Survey in select districts in preparation for the roll out of the UNFPA/UNICEF JP on FGM. . Training of members of GBV/FGM networks (community, district, Christian) was conducted, so as to build consensus and create a

common understanding of the harmful effects of FGM. The programme also supported the establishment of the National Committee on Abandonment of FGM - NACAF, coordinated by the Ministry of Gender and Social Development.

Supporting Activities Aimed at Enactment of Laws that Address Harmful Practices, Particularly FGM and Early Marriages

The programme supported selected agencies and partners to undertake an analysis of existing gender-related policies and laws in order to identify gaps on FGM and early marriage issues. Consultative meetings with interest groups were held to highlight identified gaps and develop and implement action plans and strategies that included the amendment and enactment of relevant legislation. To this end IPs were supported to lobby policy makers, including parliamentarians to draft the FGM Bill and its enactment into law to assist in the acceleration of the abandonment of FGM. Policy dialogue and advocacy employed to achieve this initiative. One hundred and fifty-five (155) police officers were trained on FGM as well as on the consequences of violating the new FGM law. Women, girls and health providers were also sensitized on the new law, especially in the areas where the practice was found to be rampant.

Scaling Up Sensitization of Community Leaders on the Need to Abandon FGM and Early Marriage

Community dialogue as an approach in addressing FGM proved quite successful. The programme facilitated key stakeholders to scale up and hold educational forums for community leaders who in turn facilitated community dialogues. In addition, the programme supported the capacity building of selected agencies and partners to enable them to re-design mechanisms that used culturally sensitive approaches to promote the abandonment of FGM and early marriages. Support for advocacy for SRHR of women and adolescent girls including on HIV/AIDS and initiatives that facilitated male involvement in SRHR issues were supported by the programme.

A total of seven implementing partners were trained on social norms, including FGM and SRHR. Eight community dialogue workshops on the implementation of the prohibition of FGM Act 2011 for community leaders was held where a total of 1,103 (590 Women and 513 Men) community leaders were sensitized. Educational forums for community leaders were further held on the implementation process of the National Policy for the Abandonment of FGM and a Plan of Action to guide Prohibition of FGM Act, and on the Draft Sessional paper for the FGM Policy. As a result, five public declarations were held in Meru, Kuria, IL Chamus, West Pokot and Kisii and public statements made in Naivasha in relation to the campaign on the Abandonment of FGM.

Though there were public declarations by leaders from various communities, evidence showed that FGM and other harmful practices still continued, with the 'medicalization' of FGM occurring in the same places. The effectiveness of these declarations therefore call for assessment to determine whether there is any behavior and attitude change towards gender equality, and support towards the eradication of harmful practices including FGM. A total of 139 health providers were trained to assist in the prevention of FGM and health providers were used in linking of the GBV/FGM working groups.

Support Alternative Rites of Passage and Appropriate Safety Nets in Selected Districts

Implementing partners were supported in the focal districts to scale up activities leading to Alternative Rites of Passage (ARP). This approach produced role models and created "Ambassadors of Change" while also creating awareness on alternative sources of income to reformed traditional practitioners of FGM. The programme evaluated existing safety nets, and recommended scaling up of existing ARPs, assessing their effectiveness and documenting best practices. A total of 586 girls underwent Alternative Rites of Passage, 35 girls refused to undergo FGM while 13 boys became champions on FGM.

Promote Gender-Friendly Socio-Cultural Environments through Media Campaigns

The programme employed media campaigns and behaviour change communication in addition to promoting a gender-friendly socio-cultural environment. This was realized through support for the development and operationalization of a media strategy to guide media campaigns against FGM and other harmful

practices. It supported implementation of selected activities in the media strategy aimed at abandonment of FGM and other harmful practices, including early marriage, sexual exploitation and GBV. The programme supported a total of 402 media reports on gender related issues. The programme also strengthened coordination and partnerships in line with the FGM National Action Plan (1999-2010) to disseminate information and accelerate the abandonment of FGM practice.

The resultant effect was found to be the increased coverage of stories aired on Radio and TV and in the print media. For instance, in 2010, gender related stories covered increased from 60 to 200. The 16 days of Activism against Violence, the World Population Day and the State of World Population and the International Women's Day (IWD) provided an avenue for airing issues related to gender equality in the media. Capacity development for reporting on gender related issues for journalists were also supported by the programme through trainings. For example, 25 journalists received training on the Kenya Rapid Model and Gender-Based Violence while 20 were facilitated to write stories on gender-based violence and related issues such as maternal and infant mortality, contraceptive use, youth and sex, fertility rate and the distribution of resources and its effects on education opportunities. The trainings focused on RH, PD, GBV, FGM, HIV/AIDS and the impact that they had on the development of the country as well as on good reporting.

Summary of Findings

UNFPA supported Gender Equality (GE) Component and the achievement of its outputs in the 7th CP by ensuring it remained relevant as a stand-alone component. The activities under the 7th CP were adequately designed to achieve the expected CPAP results. However, the main challenges affecting GE component were socio-cultural factors and perceptions that influenced achievement of gender equality and limited the utilization of both reproductive health and legal services. The implementation rate of the GE outputs was on course and in some cases, surpassed targets as defined at the beginning of the programme. Some of the best practices/strategies that ensured successful achievement of GE outputs are attributed to the close and cordial working relationship between UNFPA/GOK relevant ministries, UN agencies, development partners (donors) , IPs (NGOs, CBOs, and FBOs) and communities. This greatly improved the coordination efforts and provided access to the sub-national level, thus enabling easy mobilization/dialogue, advocacy and capacity building. The capacity building efforts for stakeholders, including government agencies on gender equality and other gender related issues however, needs to be continuous.

At the national (policy) level, the engagement of members of parliament, through lobbying for support amongst the male parliamentarians drew immense support to the Gender Bills, during the enactment of the Prohibition of FGM Act, 2011. Working within the parliamentary calendar and targeting parliamentarians, proved to be a key strategy as it was both cost effective and efficient. There is however, need for continuous lobbying and advocacy on gender bills, policies and resources for their full implementation. Without adequate resources for gender equality, including SGBV, gender equality issues are bound to face challenges in terms of effective implementation of interventions.

Gender equality issues are dynamic; hence there is a constant demand for accurate baselines and data collection for trends to properly mitigate and provide effective and efficient support to interventions. Innovative mechanisms for dealing with GE issues also need to be developed and replicated or up-scaled where possible, as majority of the issues are similar, though occurring in diverse environments and are embedded in socio-cultural norms that may vary from one location to another.

Achieving gender equity is critical to sustainable development. In all societies women's and men's roles are socially-constructed, but all too frequently gender-based disparities exist. This reality impedes development. The programme needs to consider the concept of gender equality and equity as a fundamental principle in all its programming areas, so that men and women realize their full human rights and potential to contribute to national, political, economic, social and cultural development, and benefit from the results. Gender related issues need to consciously be mainstreamed in SRHR and PD, so as to make a positive contribution to the achievement of not only Vision 2030, but also of MDG 5 (A and B).

4.4.3 Efficiency

To what extent were activities and resources managed in such a manner as to ensure delivering of quality outputs in relation to resources used?

Estimation results for efficiency of disbursements for this component showed that despite receiving only 15% of the total programme basket GE outputs were achieved within the resources allocated but at varying levels of efficiency. A comparison of 6th and 7th CP for GE showed that the 7th CP was more efficient in 2009 and 2010. Therefore, the 7th CP in the first four years was more efficient than the 6th CP in its first four years, as illustrated in Table 23.

The 7th CP efficiency analysis covered the period 2009-2012 over which assessment of the relationship between mobilized and expended resources was conducted for the gender equality component and results are reported in Table 17, with 1 interpreted as the most efficient level.

Table 17: Efficiency across 7th CP - 2009-2012

Years of Implementation	Gender Equality (GE) Calculated Efficiency
2009	1.000
2010	0.914
2011	0.851
2012	0.789
Mean	**0.888**

The efficiency in GE component decreased throughout the period under consideration, and 2009 was the most efficient. The allocations for 2011 and 2012 were found to be inefficient at levels well below the mean. **Tables 18 and 19** report efficiency analysis by ratios. Results show that over the programme cycle, disbursements to GE were not very efficiently allocated in all the years except 2010, with all the other implementation rates falling outside the acceptable statistical bounds.

Table 18: Efficiency Analysis by use of Rates of Expenditure and Mobilised Resources

Year	Target	Mobilized Resources	Expenditure	Implementation Rate
2009	$350,000	$401,725	$431,025	107.3
2010	$250,000	$341,843	$335,411	98.1
2011	$150,000	$307,482	$280,683	91.3
2012	$150,000	$731,091	$412,668	56.4

Table 19: Efficiency Analysis by use of Ratio of Expenditure to Mobilised Resources

Component	Implementation Ratio				Mean	Standard Deviation
	2009	2010	2011	2012		
Gender Equality Component	1.072	0.981	0.912	0.564	0.882	0.222

Table 20 reports efficiency comparisons between the 6th CP and the 7th CP. Results show that on average, the 6th CP had a higher level of allocative efficiency for the GE component than the 7th CP.

Table 20: Efficiency Comparison for the 6th and 7th Country Programmes in the First Four Years of Implementation

Year of implementation	Gender Equality Component		
	6th CP	7th CP	Mean
1st year (2004 vs. 2009)	0.911	1.000	0.955
2nd year (2005 vs. 2010)	0.977	1.000	0.959
3rd year (2006 vs. 2011)	1.000	0.903	0.951
4th year (2007 vs. 2012)	1.000	0.801	0.900

From a broader perspective the Joint UNFPA/UNICEF programme did in some way enhance efficiency leading to many successes for the GE component as witnessed in Output 3 results. This can be attributed to the reformed approach of working within the UN Joint programming approach and 'Delivering as One' initiative. Through the coordination mechanisms put in place by UNFPA funds were disbursed for the planned activities with IP's organized around three outputs with specific mandates to assure maximization of resource utilization. This presented an opportunity for coordination and the realization of greater impact. For instance around Output 3 on FGM/C the agenda was eventually embraced by several IP's including KEWOPA, MYWO, FIDA, WEL amongst others working at the policy level, while other IPs with comparative advantage at community mobilization and community outreach worked at the community level with far reaching effects.

4.4.4 Sustainability

To what extent are the benefits likely to continue beyond programme termination? Has UNFPA been able to support its partners and the beneficiaries in developing capacities, mechanisms to ensure durability of efforts? Were the activities, outputs designed taking into account a reasonable handover to local partners?

The gender equality component focused on utilizing existing structures that communities could relate with such as faith based institutions which enabled effective anchoring of transformative change in gender relations. For instance, through UNFPA support and the existing Government structures, the collaborating IPs were able to form, coordinate, facilitate and implement community level interventions that contributed to the success of the GE programme. Interventions such as Community Working Groups, Community Watch Groups, Community Dialogues all contributed to the management and response to issues such as SGBV and FGM/C, early marriage, etc. The involvement of men as champions against FGM and other human rights violation also impacted positively on the programme. Coordination by the Ministry of Gender and Social Development offered a viable structure for sustaining actions around the gender component since it had a strong infrastructure through to the district level with the Social Gender Development workers and Children officers.

Levels of literacy in the community, exposure to various laws, policies and regulations guiding gender equality was however found to be low. Through structured training of CBO's , however, members can be used to cascade skills learnt and to spread the creation of awareness thereby helping them to better claim their rights.

Human Resources at UNFPAs KCO and Programme Implementation

The country office organogram was composed of a Representative, Deputy Representative, and two Assistant Representatives; one in charge of Sexual Reproductive Health/Rights and the other combining Population and Development and Gender Equality. Additionally there existed an Operations Manager to complete the team of 5 who constituted the Senior Management. Each component area had Programme Officers who carried out the daily technical functions. The Sexual Reproductive Health and Rights component had two Programme Analysts; one for HIV/AIDS and SRH/OF and the other for SRH/Youth, while the PD/ Gender Equality had one Programme officer for Gender. The Country Office equally had an M& E Officer whose mandate cut across all components.

The programme was supported by a Personal Assistant to the Representative, two Programme Assistants, an Administrative/Finance Associate, and Administrative Associate, two Administrative Assistants, an Information Technology Associate and three drivers. The KCO had two NPPPs, one in charge of Humanitarian Response and the other tasked with Population and Development responsibilities. In addition, the office had a Senior Communications Officer and three Junior Programme Officers in the areas of Resource Mobilization and Aid Effectiveness, RH and Commodities Security and PD and Gender. These additions to the office had been hired on the basis of a human resource needs assessment finding.

Moreover, the UNFPA country office had seconded National Project Professional Personnel (NPPPs) as technical focal persons to specific Ministries/ government departments. The recruitment of these NPPPs was done by UNFPA upon the request of IPs, in line with UNFPAs strategy to support and build capacity of IPs through technical assistance. By the time of this evaluation, there were a total of six NPPPs Gender and Equality commission (3); NACC (2), NCPD (1) and DRH (1). The office was also in the final stages of hiring one NPPP for KEMEP. Within the Programme Cycle, two NPPPs who had been seconded to the Ministry of Gender, Children and Social Development, and the Ministry of Youth Affairs and Sports left the organization. All NPPPs had dual reporting lines; to the IP and to KCO with the exception of the two based at the UNFPA Kenya Country Office.

In reviewing the terms of reference of the focal persons, one of their most important roles was found to be the monitoring of programme activities and preparation of reports for government as well as UNFPA. However, given the paucity of data and weaknesses in monitoring referred to earlier, it would seem that the NPPPs are underutilized as a resource, yet their appropriate utilization has the potential to swing the quality of work and highlight the contribution by UNFPA to national priorities.

KCO currently has one M&E officer, who from the organogram seemed to be working without proper support and coordination with the programme. However, on further interrogation it was clarified that although the organogram does not clearly bring out the linkages, the M&E Officer worked in close consultation with the other units at the operational level. The work of the M&E Officer was thus cross cutting in nature and entailed the coordination and operationalization of a system of results-based planning, monitoring, evaluation and reporting. In the current dispensation, the monitoring and evaluation officer plays the lead role in improving the quality and results orientation of UNFPA-supported policy and programme interventions and in developing institutional and national capacity in results-based management (RBM). The organogram therefore needs to be revised to show the interlinkages while at the same time ensuring that every unit has a stronger role to play in monitoring and evaluation so that it is well integrated.

In the discussion with KCO technical staff, heavy workload was cited as one of the reasons programme officers were unable to effectively discharge their duties. Reference was made to the capacity of other UN agencies and it was clear that limited staff capacities at UNFPA compared to other Development Partners presented challenges in terms of visibility, negotiation and direct impact. Their participation and contributions at meetings therefore seemed to go unnoticed or simply overran.

Given their small numbers, they were at times unable to attend all meetings to the disadvantage of the organization. Similar views were also expressed by development partners and other government departments. There is therefore need to create a layer of technical staff within the UNFPA KCO who have experience in advocacy, policy analysis and stakeholder coordination to provide a commanding voice at both national and international level in pushing forward UNFPA's Agenda; to increase the visibility of the office. These may involve re-defining the roles of staff within the current organogram as well as carrying out re-alignments in relation to their counterparts in the other organizations.

Chapter: FIVE

STRATEGIC POSITIONING

The strategic positioning was assessed on the basis of three criteria: strategic alignment, responsiveness and added value. Strategic alignment was further split in to two, the corporate and systemic dimensions. The new UNFPA strategic plan (2008-2011 revised 2012-2013) was developed to serve as the centrepiece for organizational programming, management and accountability for the period 2008-2011. The plan responds to General Assembly resolution 59/250 on the triennial comprehensive policy review of operational activities for development of the United Nations, and takes into consideration the new aid environment. The plan sets the strategic direction and provides the overall framework to guide UNFPA support to programme countries to achieve their nationally-owned development objectives in the focus areas of population and development, reproductive health and rights and gender equality. The strategic plan consists of: (a) a development results framework, which outlines goals and outcomes for UNFPA in the focus areas; (b) a management results framework; and (c) an integrated financial resources framework.

The 7th country programme was found to be well aligned to the strategic plan with its focus on meeting the millennium development goals by addressing reproductive health and rights, population and gender equality resonating well. The 7th CP focused on areas considered most strategic for UNFPA in the context of national priorities, the UNDAF results framework and UNFPA comparative advantage. Key elements of the ICPD agenda remained incomplete, and with only a few years to the 2015 completion date for MDGs, many of the goals remained far from being met. Of particular concern was MDG 5 that UNFPA most directly contributes to – which evidence showed to be the furthest from attainment.[8] Partly as a result, maternal health, and sexual and reproductive health (SRH) became the focus of renewed attention in recent years, both at the United Nations and at the regional and national levels, creating an opportunity for UNFPA (MTR revised strategic plan 2008-2013) to exercise its mandate.

To improve the strategic focus of KCO, the Strategic Plan Mid-Term Review process re-examined the division of Development Results Framework(DRF) into three areas as well as the identification of the most critical target audiences for UNFPA work. The revised strategic plan re-focused the new DRF by consolidating and focusing on a limited set of strategic priorities as reflected in a reduction in the number of outcomes from 13 to 7. Additionally and in line with the new strategic direction, an integrated agenda for population and development, SRH and reproductive rights and gender equality was developed.

The goal of the new strategic plan is to achieve universal access to SRH (including family planning), to promote reproductive health rights, to reduce maternal mortality, and to accelerate progress on the ICPD agenda and MDG 5 (A&B), in order to empower and improve the lives of underserved populations, especially women and young people (including adolescents); enabled by an understanding of population dynamics, human rights and gender equality and driven by country needs that are tailored to the country context.

5.1 Corporate Strategic Alignment

The United Nations Development Assistance Framework (UNDAF) falls under the umbrella of One UN. The four pillars central to the reform are: One UN Programme; One UN budgetary Framework; One Leader; and one Office. The Delivering as One (DaO) Programme was adopted by the UN in 2006 and was designed to ensure consolidation and coherence of UN activities in line with the principle of country ownership at country, regional and headquarters levels; to establish appropriate governance, managerial and funding mechanisms to empower and support consolidation, and to link performance and results of UN organizations to their funding; and also to ensure a focus on outcomes, responsiveness to needs and the delivery of results as measured by advances on the MDG goals.

8 World Bank and International Monetary Fund, Global Monitoring Report 2011.

The UN in Kenya is a signatory to the Kenya Joint Assistance Strategy and UNFPA is one of agencies that participate in the Kenya Aid Effectiveness Group (AEG). The 7th CP was found to be well aligned with Government of Kenya development goals and to have contributed to progress in achieving these goals as articulated in the Vision 2030.

UNFPA was found to focus on areas where it had comparative strength in working with other UN agencies to deliver joint projects. UNFPA adhered as expected, to the Paris Declaration and Accra Agenda for Action principles of ownership, alignment, harmonization, managing for results and mutual accountability by providing support to government priorities for reproductive health, population and development and gender and supporting Implementing Partners (IPs) in their priorities. The Government of Kenya (GoK) launched Vision 2030 in 2007. This blue print rests on three pillars (governance, social and economy). Through five year Medium Term Plans (MTPs) and Budgets, the Government prioritized steps in implementing Vision 2030. Based on the MTP, the GoK sought to steer Development Partners, including UNFPA, to support them in achieving the stated goals. The GoK therefore provided the core of the funds for its development programmes and steadily increased its funding of programmes that met the ICPD agenda (eg. budget allocations towards contraceptives and free primary education) to complement UNFPA's efforts.

During the development of Vision 2030 a wide range of non-governmental actors, private businesses and civil society organizations were engaged in the process of prioritization of issues and formulation of the development strategy. At the time of evaluation, the GoK continued to engage non-governmental and Civil Society actors in the implementation and tracking of results of its Vision 2030 strategy, as demonstrated by the invitation sent to NGOs/ CSOs to participate in the Aid Effectiveness Forum and the Interagency Coordinating Committees (ICCs). An important goal of Vision 2030 was the implementation of a new constitution. Kenya successfully formulated and adopted the same in 2010. The new constitution outlines decentralization of government functions and systems. This decentralization process is expected to bring development closer to the grassroots and within communities. At the time of evaluation, the GoK with support of DPs was developing a roadmap to decentralize functions and designing the support systems for doing so.

The Kenya Joint Assistance Strategy (KJAS) presents a core strategy supported by 17 Development Partners (DP) for the period 2007–2012. It provides the basis for partners' support for the implementation of the government's development strategy; Vision 2030. It was prepared collaboratively by KJAS partners, including bilateral development agencies of Canada, Denmark, the European Commission (EC), Finland, France, Germany, Italy, Japan, the Netherlands, Norway, Spain, Sweden, the United Kingdom, the United States, the African Development Bank, the United Nations, and the World Bank Group. The KJAS presents a shared development vision and states the intentions of the Government of Kenya and KJAS partners. However, it is not a legally binding document, and individual development partners are free to discuss and, if necessary, formalize their own bilateral programs and agreements with the government.

As part of the process, attention was given to alignment of the aid architecture (Sub) Sector Working Groups (SWGs), Aid Effectiveness Groups, Donor and Government Consultative Groups and Development Partnership Forum) to the Vision 2030. A number of implications consequently resulted from this process, including the changing roles of SWGs. The GoK and DPs did agree on the mutual accountability indicators for each party, within each of the Paris Declaration's principle sectors (Ownership, Alignment, Harmonization and Managing for Results). Main challenges faced by KJAS related to the fact that not all DPs active in Kenya had contributed to its development and that major donors, such as China and the OPEC countries were not participating in the different levels of the Aid Architecture.

The Health Sector Wide Approach (SWAp) is a good example of efforts made in Kenya to harmonize support. Unfortunately, the SWAp never became fully operational due to the post-election violence and related power sharing deals which resulted into splitting up of the Ministry of Health into two; the Ministry of Medical Services and the Ministry of Public Health and Sanitation, thereby rendering the Division of Labor (DoL) irrelevant. Lack of confidence in the Public Financial Management capacities of GoK among

some donors, and the re-structuring of government architecture due to the new Constitution and its related decentralization process were some of the other causes of failure of SWAp. Evidence further pointed to UNFPA moving towards delivering technical assistance instead of downstream assistance as seen in UNFPA's support for upstream activities such as development of legislation, strategy, policy, plans, and curricula. These efforts and interventions contributed to successful legislation and policy changes that had important implications for population and reproductive health.

Kenya was not a pilot country for the "One UN" Initiative which began in 2007. This notwithstanding, the Kenya government's preference for this modality of support that provides for one leader and one funding mechanism ensured voluntary adoption of a Delivering as One (DaO) approach. In line with the Paris Declaration and within the UN, the KCO made continous efforts at reforming to become more efficient, effective and accountable, and was found to be actively involved in the UN joint programming efforts such as; HIV/AIDS joint programme; the joint programme on Gender Equality and Women's Empowerment (GEWE), and the Donor Youth, Health Harmonization and Humanitarian Forums and the UNICEF/UNFPA Joint Programme on Abandonment of Female Genital Mutilation and Cutting (FGM/C). UNFPA also worked with UNICEF and WHO in an informal working group on maternal health. To accomplish its goals, UNFPA continued to coordinate and work in partnership with other United Nations agencies, multilateral and bilateral organizations, national governments, non-governmental organizations (NGOs), including faith-based organizations, academic institutions, and the private sector.

Until recently UNFPA worked exclusively with development actors and much less with the private for-profit sector. At the time of this evaluation, there were several initiatives that demonstrated stronger engagement with the private sector and building of partnerships. Examples included Funds from Packard Foundation for FP and Youth in Muslim communities, a pilot of PAAL SMS FP commodity tracking system; participation in Global Compact Network and other corporate workshops. In working with these partners, UNFPA focused on its comparative advantage as a thought-leader, advocate, and partnership-broker to advance the ICPD agenda and the MDGs. UNFPA was also keen on South-South cooperation as evidenced by its support for missions to India and Korea.

Within these programmes there was a clear division of labour with each of the UN agencies contributing in line with their core mandate and this was reported to work well. UNFPA also scored well in its partnership efforts, such as contributing to policy dialogue at country level, as assessed, for example, in the 2010 Multilateral Organisations Performance Assessment Network (MOPAN) review. UNFPA is also recognized for contributing to United Nations reform efforts at the global level in terms of chairing committees and task-teams and at regional level for leading strategic exercises in areas such as youth and maternal health. A more recent initiative was the lead role UNFPA played in the launch of the Campaign for Accelerating Reduction in Maternal Mortality in Africa (CARMMA) in 2011. In Kenya the Ministry of Public health and sanitation regarded this event as catalytic for Maternal Health.

The 7th CP showed commitment to the development of national capacity by paying attention to the Guiding principles: national ownership and national leadership. In terms of programming, attention was directed towards the most vulnerable, disadvantaged, marginalized and excluded populations as well as to mainstreaming of young people's concerns. UNFPA was, at the time of this evaluation, a member of the reproductive health sub-cluster of the health cluster, led by the World Health Organization and of the Gender Based Violence sub-cluster in the protection cluster, led by UNHCR. UNFPA also extended its working relationships to include other organizations such as GIZ, Save the Children, IRC and UNHCR who have working experience in humanitarian response. As an organization UNFPA was found to be relatively better placed to react to crises and that it had an important contribution to make in the delivery of SRH services as part of humanitarian response compared to the previous country programme cycles.

5.2 Systemic Strategic Alignment

At the Systemic level UNFPA played a key role alongside other UN agencies. From 2012 became the chair of the Development Partners for Health in Kenya (DPHK)

and was also a member of the Reproductive Health Harmonization Forum in Kenya at the time of this evaluation. The CPD and the CPAP were found to be well aligned to UNDAF in which the interests, priorities and mandate of UNFPA were reflected. Within the UNDAF-Kenya UNFPA took a leading role in Governance. The agency was an active member of outcome one of the UN joint programme on HIV and AIDS that focused on the biomedical aspects of HIV and AIDS including RH and condom programming. It remained the key agency in HIV prevention and communication strategies and had recently been joined by World Bank and UNDP. In addition, the M&E programme officer within UNFPA was, at the time of evaluation, the convener of the UN M&E working group. In addition,, UNFPA co-chaired the UN Youth Joint Programme with ILO. Evidence also showed a high degree of coordination between UNFPA and other UN Agencies particularly in programme areas where there was potential overlap. For example although both UNFPA and UNICEF worked on FGM/C; each agency was in charge of a defined geographical area to avoid overlap and this reflected a high level of complementarity.

5.3 Responsiveness

UNFPA worked through the government; aligning its programme support to priority needs and worked within the established policy framework and the national execution plan of the Kenya government. There were focal points within the government that enhanced programme implementation, which were supported by UNFPA based on government or implementing partner's request. Capacity building was a key challenge for the government over the programme cycle and UNFPA responded by supporting trainings to meet the needs of the government. Timely response to government requests was observed even outside the programme design as was the case with emergency support during the post-election violence. UNFPA came in to provide reproductive health services and commodities through Kenya Red Cross Society of Kenya and International Rescue Committee (IRC). Consequently, UNFPA did take up emergency response as a core activity and towards this end; there were plans to build a health facility in Daadab Refugee camp.

5.4 Added Value

UNFPA displayed a close and consultative working relationship with its partners and was also regarded very highly by other development partners. As an agency it scored well in its partnership efforts, such as contribution to policy dialogue at country level, as assessed, for example, in the 2010 Multilateral Organisations Performance Assessment Network (MOPAN) review. UNFPA was recognized for contributing to United Nations reform efforts, at the global level through chairing of committees and task-teams; at regional level in leading strategic exercises in areas such as youth and maternal health and at country level through joint initiatives. UNFPA consequently carved itself a niche in responding to humanitarian crises by providing SRH services that are critical but often overlooked during crises.

Evidence further showed that UNFPA had a comparative advantage in population and development as exemplified by its long time support for population censuses as well as Kenya demographic and health surveys over the years. Within the area of reproductive health, the focus on planning and its related role in population and development placed the agency in the lead. From the key informant interviews with other UN agencies, development partners and the government it became clear that this was the natural niche that UNFPA needed to re-affirm. The Key informants from GOK in particular noted that UNFPA had a strategic focus on key areas that were also of priority to the Government agenda for a long time to come- the population, health sector and gender as cross-cutting. These are areas that were likely to create impact in the long run.

From the key informants at the national level it was observed that given UNFPA's mandate as an agency and its proximity/accessibility to the government and policy makers it could be more visible than is demonstrated at the moment and that it had the potential to take a more proactive leadership role in population and related RH&R and gender programme areas. The implementing partners and the beneficiaries lauded the contribution of UNFPA and alluded to a close and cordial working relationship. The beneficiary assessment of UNFPA was positive. Examples in RH and rights include responses from obstetric survivors, commercial sex workers involved in income generating activities, youth who

had access to a wide range of services and service providers who had benefited from training. Support for improvement of infrastructure at health facilities was appreciated for its contribution to provision of quality services. In the population and development arena capacity building for staff and support to data collection and analysis was lauded. Gender mainstreaming and facilitation to enactment of laws as well as support towards creation of awareness on gender issues put UNFPA in the forefront in the field of gender and equality.

Chapter SIX

TRANSVERSAL ASPECTS: MONITORING AND EVALUATION

The M&E framework for the 7th Country Programme was the first of its kind in the history of UNFPA in Kenya. It was anchored on the principles of results based management. This framework linked the CP to the relevant M&E systems in the country through a number of well defined M&E mechanisms, including coordination and reporting, programmes component review meetings, mid-year programme review meetings, annual programme review and planning meeting, UNDAF annual review meetings, mid-term programme review meeting, data collection and management, field monitoring visits and evaluation.

Over the programme cycle, a number of mandatory M&E activities were undertaken with mixed results. A CPAP M&E plan was developed for the first time, though belatedly, with a view of strengthening the existing M&E system. This framework defined a fairly comprehensive M&E plan that was targeted at defining data sources, means of data collection and identifying action heads for data collection and analysis. The plan, apart from defining a nine-point M&E mechanism, also defined four M&E tools including CPAP Planning and Tracking Tool, GOK/UNFPA 7th Country Framework of Annual Targets, CPAP Monitoring and Evaluation Calendar and the Annual Work Plan. The M&E plan also identified five reporting tools to be used including the Work Plan Monitoring Tool, Standard Progress Report, Field Monitoring Visit Report, FACE Form and the Evaluation Terms of Reference.

In addition, base-line and end-line data for a number of indicators were developed and targets set over the programme cycle. Done at all levels of results (i.e UNDAF outcomes, CP outcomes, CP outputs and major activities) the development of indicators was quite an ambitious undertaking involving the formulation of some 98 indicators. Out of this total, activity level indicators accounted for 59 percent, outcome level indicators 22 percent and output level indicators 18 percent. Some 58 percent of these indicators were however formulated without baseline data.

At the output level, 60 percent of all the RH indicators did not have baseline data as did 86 percent of the GE indicators. All the PD indicators however had baseline data. At the activity level, 64 percent of the RH indicators were formulated without baseline data as were 94 percent of GE and 11 percent of PD indicators. At the outcome level, all the RH indicators had baseline data, but 43 percent of the PD and 50 percent of GE indicators did not have any such data. Additionally, at the output level, 14 percent of the GE indicators did not have targets and at the outcome level, 29 percent and as did 25 percent of the PD indicators. A critical omission at this stage was the development of an indicator reference sheet to support the interpretation of indicators.

Monitoring and evaluation field visits at regional level to monitor the NCPD work plan and the regular GOK/UNFPA joint field visits are necessary in monitoring programme implementation. Over the programme cycle, the M&E plan envisaged bi-annual field monitoring visits. This was subsequently whittled down to six planned visits to project sites particularly to the focal districts. By March 2012, only three of such visits had been carried out placing in doubt the possibility of meeting the relevant joint field monitoring targets. Field visit reports provide valuable information (both qualitative and quantitative) that may not be obtainable from written reports. Whereas only a limited number of joint field monitoring visits were conducted, this was adequately made up for by sustained field monitoring by UNFPA over the entire programme cycle.

In order to track and review progress made in attaining planned activities, all the IPs continued to effectively and consistently use the work plan monitoring tool. This tool facilitated reporting on a quarterly basis with regard to progress towards achievement of annual targets, as well as facilitating factors and constraints. Prepared alongside this was the standard progress report. In order to document progress on the achievement of CP outputs, their contribution to CP outcomes as well as UNDAF outcomes, all the IPs consistently prepared and

submitted standard progress reports on quarterly and annual basis.

To enable the CO to take stock of programme performance and assess progress achieved in every year of the programme cycle, a total of four mid and annual programme review meetings were planned on an annual basis and these were successfully held over the period 2009 to December 2012. The reports of the said meetings served an important monitoring and evaluation function by providing a basis for responding to new opportunities and emerging issues.

The CP M&E mechanism provided for UNDAF Annual Review Meetings as a platform for UNCT to engage the GOK and other partners. Over the programme cycle however, no such meetings took place. Instead, two stand-in cumulative annual progress reports for the periods 2009/2010 and 2011/2012 were prepared by UNCT. The data used to prepare the reports was obtained from various UN agencies thereby making the process consultative.

This notwithstanding, the process as operationalized, served to reduce the level of participatory and all inclusive assessment of progress towards results and also made it difficult to take stock of lessons and good practices in a more comprehensive manner. Besides, the cumulative nature of the stand-in reports made it difficult for the said reports to inform in a timely manner, the planned annual planning processes and commitments for the coming year as originally intended.

To allow for assessment of the status of CP implementation based on established benchmarks for all the programme components, a mid-term programme review meeting was conducted in 2011 as planned to run concurrently with the mid-year review meeting. This development was necessitated by the need for stakeholders, particularly the IPs to take into consideration the findings and recommendations of the mid-term review in planning for the future. To prevent loss of details of the broad agenda of this very important M&E exercise, it is recommended that in future, such an important exercise be given the time, space and prominence it deserves in the M&E calendar.

For each of the programme years of the 7th CP, Country Office Annual Reports were consistently prepared. These reports served an important function by providing the broad framework for taking stock of programme performance in relation to both internal and external threats. They served to highlight key achievements, key shortfalls in the implementation of UNDAF, CPAP and AWP for each year as well as the most important interventions undertaken to achieve results. The COARs were found to be important because they shed light on the external environment with a particular focus on how this affects UNFPAs role and performance in the country.

Evaluation of demonstration/pilot projects and evaluation of major country programme outcomes are mandatory M&E activities. Over the programme cycle, two pilot projects were selected in Kenya as case studies for thematic evaluations. These were the Maternal Health Thematic Fund and the UNFPA/UNICEF Joint Programme on FGM/C with the latter project found to be on-going at the time of this evaluation. Despite its significance to the country programme M&E process, evaluation of major country programme outcomes had not been conducted by the time of this evaluation as had been envisaged in the 7th CP.

Data collection and management is a critical component of any M&E framework. In the 7th CP, IPs were charged with the responsibility of collecting information on process indicators relevant to the activities they implemented. The CP intended the defunct Program Cycle Manager to be responsible for routine data collection on both functional and service outputs that related to targets of their respective programme components. With their abolishment, this task was passed on to NCPD which already had the overall responsibility for coordination of the implementation of the national population plan in addition to hosting the national database for the country programme.

At the outcome level the ministries responsible for data collection and analysis all did a commendable job, but one which could be improved upon, particularly in terms of data analysis and reporting. At the IPs level appropriate data capture and reporting was found to be problematic over the programme cycle due to limited use of designated data capture tools. This had in turn constrained flow of new information to the established data bases such as GBV-IMS and IMIS. Limited flow of information appeared to have impacted adversely on data management with most of the databases

(especially GBV-IMS and IMIS) not getting regularly updated as initially planned.

At the national level, effective coordination of the government, UNFPA and the IPs by NCPD ensured a significant level of successful implementation of the M&E plan. Efforts to align with the revised UNFPA Strategic Plan in the year 2012 however jolted consistency of programmatic approach by disrupting the reporting lines owing to the abolishment of PCMs in the new strategic plan. It is therefore necessary that they are redefined to allow for smooth programme management.

An important component of M&E is the monitoring of the management control and assurance activities. Insufficient monitoring in this respect was reflected in the NEX audit reports for 2011 and 2010 on management control findings. In 2010, 11% of all the IPs did not exhibit sufficient audit trail. In 2011, this proportion doubled to 22%. In both years, 5.6% of the IPs did not have in place sufficient financial control policies and procedures. The same proportion exhibited poor record keeping in 2011. In the same year, 11% of the IPs displayed excessive use of cash payments. This is an indictment especially on the monitoring of appropriate usage of the financial control tool.

To assess the status of implementation of the 7th CP, two evaluation exercises were scheduled over the programme cycle. The present exercise, preceded in 2011 by a mid-term evaluation, is a testimony of the COs support for national-led evaluation targeted at strengthening national evaluation capacity.

6.1 Monitoring and Evaluation System in the Country Office

Monitoring of Inputs and Activities

Field monitoring visits are an important M&E mechanism. Over the programme cycle such visits were carried out on a consistent and regular basis with a view to monitoring programme implementation. The reports for each visit were compiled and submitted in a standard reporting format and shared with stakeholders in mid year and annual programme review meetings. The reporting format for such visits was quite comprehensive and they captured sufficient qualitative and quantitative details that were not easily obtainable from written reports. This mechanism would however have been much more effective with strengthened joint monitoring by both operational and programme staff of the CO. Monitoring efficiency gains was however, eroded by some ineffective embedded national experts. For example the GBV IMS database hosted at the Commission was not accessible and was not frequently updated to support M&E.

Follow-up of budget expenditure compliance is an important component of financial inputs monitoring. A common indicator of sufficient follow-up is the rate of compliance with financial reporting procedures. The 2011 NEX audit results showed an increase in the number and severity of audit findings compared to the two previous reports. Comparative cross-yearly analysis however showed that no clear non-compliance trend was discernible.

A high rate of non-compliance was reflected in the NEX Audit opinion of 2011 with 17% of IPs receiving adverse opinion and 33% receiving qualified opinion. In 2010, none of the IPs received qualified opinion but in 2009, 29% of the IPs received qualified audit opinion. Two reasons were cited for this unusually high level of non-compliance; the accounting treatment of commitments as expenditures and the general transition/coordination dynamics from KENAO to Moore Stephens as the UNFPA auditors. The matters raised by the auditors were however, promptly resolved during the NEX audit compliance phase and the unspent balances refunded to UNFPA.

Additionally 27.7% of IPs in 2011 and 6.5% of IPs in 2010 did not have sufficient documentation to support expenditure while 11% and 0% respectively, did not have supporting documentation at all. Notably too, 67% of IPs were not able to complete the FACE forms correctly in 2011. This inconsistency could be an indicator of an M&E system whose enforcement function requires strengthening.

An effective budget expenditure follow-up system should be able to pick-up any deviations from targets and map out appropriate interventions. Evidence from core and non-core budget expenditure reports confirmed otherwise. The average rate of project implementation for non-core budget expenditure was estimated at 8%

for components and that for core budget expenditure by IPs at 44%. This was found to be a critical indictment of the monitoring function of the CO; and was directly related to probable systemic failures in target setting in project implementation.

The AWP is an important tool for monitoring implementation of the 7th CP. All IPs prepared activity reports regularly and the AWP yearly. The latter described activities for each output and the relevant implementing partner. The rate of compliance to reporting requirements for the CP was however found wanting. A compliance assessment of 17 IPs on the basis of their 2011 AWPs and second quarter SPRs showed that 59% of IPs did not meet the requirement of stating the actual expenditure per every activity implemented in their reports and that 41% did not carry out activities as per the AWP. This was therefore considered a weak link in the CO M&E because poor reporting could compromise evaluation of programme success significantly.

A critical issue raised in the audit reports of 2010 and 2011 was the vaguely defined budget lines in AWPs which were amenable to misinterpretation and which therefore hindered effective monitoring. Performance of UNFPA CO in monitoring activities through regular participation in UNFPA/GOK meetings was found to be sufficient but was hampered by occasional failure of IPs to schedule their M&E activities well in advance so as to accommodate UNFPA participation.

Monitoring of Outputs and Outcomes

The system of monitoring of outputs and outcomes is based on the CPAPs' M&E framework including the M&E plan, M&E calendar and the CPAP results and resources framework. The CO's monitoring system for output and outcomes showed some systemic and process frailties. The M&E plan defined data sources, means of data collection, frequency of data collection, and who should collect and analyse what information but it did not define the level/depth of information or analysis required. Consequently insufficient and inappropriate data was at times collected and making systems update difficult. An example is the GBV database.

Information flow was another hindrance. Although the system defined the reporting lines, alignment with the revised UNFPA Strategic Plan had disrupted the same owing to abolishment of PCMs. To make monitoring effective, there is need to redefine the reporting lines. Information flow was further hampered by limited use of appropriate templates for capturing the same. In one of the focal districts, partners developed their own templates for capturing information. In addition the system was not structured to provide regular feedback to local partners. Limited information relating to results achieved acted to impede evidence which is an integral part of monitoring.

The 7th Country Programme Monitoring and Evaluation calendar is an important tool for monitoring outputs and outcomes. As crafted, the calendar was considered detailed, informative and properly sequenced to provide the necessary anchorage for the whole M&E framework.

The CPAP Planning and Tracking Tool was found to exhibit some inherent frailties relating to formulation of indicators and indicator-output mapping that prevented the monitoring system from being results oriented. This was in spite of the two UNFPA supported RBM capacity building workshops. The RBM Compliance Monitoring Report (2012) showed that compliance to requirements of reporting on results was still very low among the IPs with a majority of them still reporting on activities only instead of extending the same to capture the link between activities and results. The report showed that 41 percent of all IPs did not comply with all the reporting requirements and that 65 percent of all the IPs were in fact not reporting appropriately by failing to capture the linkage between the various activities they implemented and the corresponding outputs.

The lack of functional results oriented system was considered attributable to a number of factors. 75 percent of respondents saw this as more of a process generated problem, i.e., how and who does the reporting and cited the turnover of staff particularly in government IPs. Weak formulation of indicators and outputs was also cited as a possible cause by 75 percent of respondents. The indicators were found to be not only too many but that some corresponded to higher level results. Some of the indicators were not relevant or realistic while others were not specific and still others were difficult to operationalize. Besides, a majority of them did not have

a baseline. Consequently, it was difficult to use the said indicators to measure the degree to which results had been achieved.

For example, in the 7th CP, the GoK/UNFPA Planning and Tracking Tool had a total of 98 indicators and 58 percent of these did not have baseline data with a majority of these (32 indicators) being activity level indicators. In addition, 50 percent of all the 18 output indicators did not have baseline data. Besides, 13.6 percent of all the outcome level indicators did not have targets.

A peculiar feature of the 7th CP was the mismatch between indicators, outputs and outcomes caused largely by the fact that an indicator reference sheet to help in the interpretation of indicators was not developed at formulation stage. Besides, no clear guidelines were provided by the CO to support the belated development of the same.

Consequently this created a very weak linkage between outcomes and output which in effect made it difficult for IPs to link activities to CP outputs. This very weak linkage was probably the reason for activity level reporting by IPs since they lacked indicators to report on. This was in spite of the fact that 'Relevance' criteria dictated that IPs report on how the various projects they implemented worked to support the broad national development agenda such as Vision 2030 and the MDGs.

In fact evidence shows that in the second quarter of 2011 for instance only 6% of the IPs reported fully on this linkage with another 12% reporting partially on the same. Majority of the IPs (82%) did not report at all on how the projects they implemented supported the over-arching national development agenda. This was compounded by the fact that the CP M&E Plan was formulated after programme inception, i.e., after outputs had been defined without baselines.

Monitoring of Assumptions and Risks

Risk management is critical in strengthening results-based management and monitoring of assumptions and risks is an important argument in risk management. UNFPAs strength in assessing information on risks and assumptions is tagged on the close and consultative working relationship it enjoys from its partners as well as the high level of value-added perception accorded to it by other development partners. The main weakness relating to risk management was that the CO had not identified the main risks and assumptions affecting the CP. As a result, UNFPA could not track information on changes in the assumptions that affected it. Additionally the monitoring of risks and assumptions was neither formalized nor recorded. This greatly compromised the benefits of sharing quality and timely information for supporting a result-based management culture.

Integration of Evaluation into the M&E System

Whereas this end-line evaluation exercise served as a guide to strengthen key areas of partnerships, coordination and collaboration mechanisms between UNFPA and its partners, sufficient attention had not been paid by the CO to the evaluation of its own internal systems with the consequence that potential gains from complementarity between mid-term and end-line evaluations on one hand and the CO internal evaluation system on the other, was severely compromised.

6.2 Support to National Partners in their M&E System and Capacity

The 7th CP was designed to link up with NIMES, the broad M&E framework for the country through various mechanisms for M&E, including coordination and reporting, data collection, management and quality assurance. In the programme cycle, this linkage was manifested in UNFPAs support for and collaboration with MED. Evidence however suggested the need to strengthen these linkages by ensuring that all reports from the 7th CP feed into NIMES reporting framework and that the CP is tightly interfaced with NIMES in terms of goals, indicator framework and reporting system.

The UNFPA Country Office also provided programmatic level support to the National M&E system through DMEC and NCPD. This support also extended to other strategic partners in M&E notably KNBS and PSRI. In the four focal districts, support of KCO included technical capacity building especially for DDOs, KNBS, NCPD and MED staff as well as several other IPs; infrastructure support in the form of office facilities and financial support for various M&E activities.

As part of its support for national partners, in the 7th Country Programmers, the programme in collaboration

with PSRI successfully conducted two Results Based Management Capacity building workshops in 2010 and 2011 targeting the Implementing Partners as well as the UNFPA country office staff.

The KCO also continued to support monitoring mechanisms of a number of IPs in the focal districts with a view to strengthening their systems. A critical omission was however the absolute lack of capacity building on evaluation for the same systems. Consequently most IPs only had the capacity to carry out monitoring. An important impediment to these efforts was the generally weak M&E culture in the government system which was compounded by an even weaker feedback system and limited horizontal information sharing in government (government emphasizes vertical information sharing).

Besides, at the time of this evaluation, various government ministries used different reporting formats which weakened the process. Arising from these differences, some ministries did not have a provision for a follow-up of supported projects. MOYAs for instance did not have strong follow-up on projects until the DDOs started targeting youth groups in M&E, an action that eventually ensured strengthened and regular repayments of youth fund loans.

Summary of Findings

The 7th Country Programme successfully supported a number of M&E activities over its cycle. This notwithstanding, the M&E function exhibited inherent systemic weaknesses which acted to compromise effectiveness. Effective monitoring was hampered by weak formulation of indicators and outputs which in turn was compounded by the existing mismatch between indicators, outputs and outcomes. This led to weak linkages between outcomes and outputs which was the main cause of activity level reporting by IPs. Monitoring and follow-up on budget expenditure compliance and appropriate usage of the financial control tool was also considered insufficient as was the monitoring and enforcement of compliance to reporting requirements.

In addition, weak monitoring of data collection, analysis and management led to constrained flow of information which in turn impacted adversely on data management. Evidence suggested further that the management of risks at the CO level was weak due to limited monitoring of risks and assumptions and that the support to IPs had focused exclusively on monitoring to the utter neglect of the evaluation component. Notable too, was the intended but very weak linkage between the 7th CP and NIMES particularly in terms of goals, indicator framework and reporting systems. Besides, sufficient attention had not been paid to the evaluation of the KCOs M&E system.

Chapter: SEVEN

CONCLUSION AND RECOMMENDATIONS

7.1 Main Conclusions

7.1.1 Strategic

At the strategic level the 7th CP focused on key areas which were also of priority to the Government and addressed health priorities outlined in Kenya Health Policy Framework (1994, 2012-2030). UNFPA was found to work through the government; aligning its programme support within the established policy framework and the national execution plan of the Kenya government. The interventions were relevant to a wide range of stakeholders including the government, non-governmental actors and beneficiaries. Other UN agencies, development partners and the government were all clear that RH was the natural niche that UNFPA needed to re-affirm.

Within the joint programmes there was a clear division of labour with each of the UN agencies contributing in line with their core mandate and this was reported to work well. UNFPA was reported to score well in its partnership efforts, such as contributing to policy dialogue at country level, as assessed, for example, in the 2010 Multilateral Organisations Performance Assessment Network (MOPAN) review. UNFPA was also recognized for contributing to United Nations reform efforts at the global level in terms of chairing committees and task-teams and at regional level for leading strategic exercises in areas such as youth and maternal health.

The 7th CP operated at both the national and decentralized levels working through government and other implementing partners. At both levels UNFPA's contribution was highly valued. By the time of evaluation, UNFPA supported national programmes as well as programme activities in 4 districts; having been reduced from 9 districts in the 6th CP. Whereas the choice of the 4 districts may have been based on poor health indicators and the presence of hard to reach areas for Migori, Naivasha and Kilifi and a poor urban environment for Nairobi West, the geographic spread of these districts was found to be a hindrance to effective monitoring and supervision of activities. Under the new UNFPA strategic dispensation and the devolution of service delivery in Kenya, UNFPA now has the opportunity to redefine the same by for instance focusing on fewer outcomes in selected districts/counties. This would also be in line with revision of the results frameworks within the UNFPA Strategic plan that is based on the need to consolidate by prioritizing; avoid doing everything everywhere, 'silo' thinking and improving measurability

7.1.2 Programmatic

Working through government structures the 7th CP realized various achievements but also encountered many challenges. The single most important contribution of UNFPA in PD was the support it gave to the national statistical system either directly or indirectly. This support acted to develop unique and critical skills and capacities and to strengthen the data collection and analysis functions thereby improving greatly the quality of data and by extension, the planning process in the country. Effectiveness of UNFPA interventions was also manifested in the progressive integration of emerging population issues into the successive annual progress reports of the Vision 2030 and in the explosion of population and environmental issues into the political discourse in the country. Efforts at strengthening the planning units were however constrained by a number of factors, key among them being resources.

The overall contribution of the RH and Rights component was founded on the support to policy development and review, capacity building through training at the various levels and infrastructural development. This was in line with the GOK agenda of increasing access to quality health care especially for women, young people and other vulnerable groups. In particular, the training of service providers served to strengthen the quality of care available. The institutional support in equipment and refurbishment of focal health facilities as well as

the logistical support in contraceptive commodity security at the national level evidently placed UNFPA at a high level of partnership with the GOK. The condom programming contributed to the management of STIs as well as the integration of RH and HIV. Perhaps the most effective strategy was the reach to commercial sex workers and the rehabilitative component that saw young girls go back to school and women take up income generating activities as a move towards empowerment.

The establishment of 4 youth friendly centres and 4 youth empowerment centres, even though not all fully functional, did boost RH service delivery to youth. The focus on adolescents and youth as vulnerable population was an important aspect of the CP. The 7th CP supported two strands of service delivery; development of Youth Empowerment Centers within the Ministry of Youth (MOYAS) and establishing Youth Friendly Centers within the Ministry of Health. However in both approaches, available service varied. For example, YECs were primarily for entrepreneurship and life skills building while YFC were largely for RH service delivery. Given UNFPAs limited resources, there was need to re-examine specific approaches to support RH for young people. Training of surgeons for fistula repair; a neglected area of RH, and the support to health facilities to offer repair services demonstrated how fistula management could be brought closer to those who needed it. The effectiveness of this intervention was evidenced by the positive testimonies of the OF survivors.

The 7th CP remained responsive to emergencies and emerging government priorities and it continued to focus on vulnerable groups. Planned activities were largely met and compared to the previous programme cycle the level of preparedness was commendable particularly with regard to prepositioning of commodities, training of staff and support to key health facilities.

UNFPA also continued to support the Gender Equality (GE) Component and the achievement of its outputs in the 7th CP by ensuring that gender equality issues remained relevant by having it as a stand-alone component. The activities under the 7th CP were adequately designed to achieve the expected CPAP results. However, the main challenges affecting the GE component were socio-cultural factors and perceptions that influenced achievement of gender equality and limited the utilization of both reproductive health and legal services. The implementation rate of the GE outputs was found to be on course and in some cases, surpassed targets as defined at the beginning of the programme. Some of the best practices/strategies that ensured successful achievement of GE outputs are attributed to the close and cordial working relationship between UNFPA/GOK relevant ministries, UN agencies, development partners (donors) , IPs (NGOs, CBOs, and FBOs) and communities.

Several strategies for sustainability were observed. Programmes were found to be embedded in national policy frameworks and GOK structures. UNFPA supported the lobbying for allocation of more resources for RH and commodities from the government. Capacity building through training of service providers and working with and through knowledge generation institution; in particular KMTC, UoN, Moi Referral Hospital was found to be an important building block for sustainability. Besides, positioning of NPPPs with IPs initiated a mentoring process and building of capacity.

Overall the programme performed well within the challenges that were often out of its control. It is acknowledged that there were challenges precipitated by lengthy GOK procurement procedures, gaps in training and cost of services. However , there were promising practices and lessons learnt for the 8th CP. Working through government structures and focusing on innovative initiatives such as support towards OF repair, creation of DICs and provision of integrated services, rehabilitation of FSWs through loans and IGAs as well as return to school for young girls; training of Community midwives in RH and the use of community structures and using male parliamentarians to lobby for legislation for the abandonment of FGM were some of the highlights of the program. Capacity building on PD issues and investment in advocacy also played a key role in revitalizing family planning.

7.1.3 Transversal Aspects: Monitoring and Evaluation

The 7th Country Programme successfully supported a number of M&E activities over its cycle. This notwithstanding, the M&E function exhibited inherent systemic weaknesses which compromised effectiveness. Effective monitoring was hampered by weak formulation of indicators and outputs which in turn was compounded by the existing mismatch between indicators, outputs and outcomes. This led to weak linkages between outcomes and outputs which was the probable cause of activity level reporting by IPs.

In addition, weak monitoring of data collection, analysis and management also led to constrained flow of information. The management of risks at the CO level was found to be weak due to limited monitoring of risks and assumptions. Notable too, was the intended but very weak linkage between the 7th CP and NIMES particularly in terms of goals, indicator framework and reporting systems. Besides, sufficient attention had not been paid to the evaluation of the COs M&E system.

7. 2 Recommendations

Strategic Level

- With the shift towards "Delivering as One" UNFPA will need to consolidate its position within UN system and establish a firm niche in reproductive health, population and development and gender equality.
- As part of upstream interventions, institutional support and capacity building of pre-service training institutions initiated in the 7th CP should be scaled-up in the 8th CP as an assurance of sustainability in RH, PD and gender training and skills development for service delivery.
- Under the new UNFPA strategic dispensation and the devolution of service delivery in Kenya, UNFPA has the opportunity to redefine its area of support. UNFPA should assume a more cohesive and holistic approach in programming by concentrating on key programme outputs/activities that are likely to make a difference and demonstrate impact. The selection of the geographical areas needs to be re-defined for effectiveness and efficiency in relation to the new governance structures as well as for easier monitoring and evaluation of programmes.
- With a draft communication strategy in place and a communication officer at the KCO it is imperative to ensure documentation and sharing of best practices with other development partners and stakeholders as a way of enhancing visibility.

Programmatic Level

Reproductive Health

- UNFPA should scale up its support towards humanitarian response in the 8th CP and engage the GOK more on the need to create capacity as well as data bases for rapid assessment and also in profiling emergencies.
- The focus on MDG5 should also address the availability of RH and family planning commodities and equipments in particular LAPMs- noting that one of the constraints for providing family planning was the lack of access to commodities. This should be accompanied by an aggressive demand creation programme that builds on the community strategy and structures that are already in place.
- Voucher system to support OF should be initiated through discussions between UNFPA, DRH and the Output Based Approach in Aid (OBA) steering committee. This initiative is already planned for takeoff on a pilot basis.
- The focus on youth remains paramount, however UNFPA should consider supporting youth within the model of youth friendly services where reproductive health is primary and where UNFPA has a comparative advantage
- Considering UNFPAs comparative advantage in the area of SRH, it is crucial that UNFPA provides technical support to the Ministry of Education (especially KIE) on comprehensive sexuality education in the school curriculum
- There is need to scale up the use of comprehensive RH drop-in centers, other HIV CT initiatives such as moonlighting, outreach and the peer approach in reaching vulnerable groups such as MARPs and SWs; to increase access to SRH/HIV/AIDS services.

Population and Development

- In the planning of the 8th CP it would be prudent to emphasize on conducting baseline survey where there is no data and to emphasize data capture by IPs to facilitate realistic target setting and trend analysis at both MTR and CPE. This could be reinforced as part of IPs core deliverables.
- To increase sustainability and demonstrate impact, it is necessary to enhance support to IPs in the knowledge industry and to invest in research, specialized studies and/or region specific surveys so as to add value and increase dissemination/visibility to the work that UNFPA supports.
- With regard to support for revitalization of vital registration systems in the focal districts, effectiveness demands that UNFPA focuses more on advocacy than infrastructure development.
- To improve overall programme performance of the 8th CP, measures should be urgently put in place to help unearth and resolve the causes of lack of compliance with RBM requirements, especially regarding reporting on results in the 7th CP. Consideration should be given to an urgent review of reporting tools, additional training in RBM and tracking of trainees and their deployment over time.

Gender Equality

- Gender equality issues are dynamic; hence there is a constant demand for accurate baselines and collection and analysis of sex and age disaggregated data to establish trends, anchor proper mitigation and provide effective and efficient support to interventions.
- There is need to address socio-cultural issues and to advocate for improved infrastructure and adequate resources in line with MDG5 so as not to lose on the gains already made towards addressing GBV and FGM/C. The capacity building efforts for all stakeholders, IPs, beneficiaries and government agencies on gender equality and other gender related issues needs to be continuous.
- Strengthening of existing and creation of new community structures is critical to act as safety nets for girls who escape FGM. This can be done by reinforcing community based structures such as community networks to prevent and respond to GBV and FGM/C and to facilitate community dialogue.
- There is need to continue strengthening the close and cordial working relationship between UNFPA/GOK relevant ministries, UN agencies, development partners (donors), IPs (NGOs, CBOs, and FBOs) and communities.
- The 8th CP should emphasize up scaling of GBVIMS in other public hospitals and enhancement of ownership by MOH, MOPHS, KNBS and MOGSD so as to provide information to aid in program planning and implementation.

Transversal Aspects: Monitoring and Evaluation

- To strengthen and place the M&E system on a firmer evidence-based footing, there is need to carry out a comprehensive evaluation of the CO M&E system.
- It is important that the M&E framework for the 8th CP be developed during the design stage of the programme and that the framework be structured to feed adequately into NIMES.
- The KCO needs to identify, formalize, document and assess the risks and assumptions affecting the CP as part of risk management and also work out mitigating factors so that there is some level of anticipation and preparedness to inform realistic target setting and to support a RBM culture
- In recognition of the importance of M&E it would be prudent to strengthen the CO M&E function/desk to manage data capture and to oversee production of reports that inform not only programming within UNFPA but also other stakeholders. In this light the roles and responsibilities of the NPPPs positioned in line ministries or IPs should be clarified so that they are able to effectively monitor and document programme activities.

ANNEX 1: MANAGEMENT RESPONSE

UNFPA Management Response		**Country Programme Evaluations (2009-2013): Kenya**		
Cluster 1: Strategic recommendation				
Recommendation No. 1		**To UNFPA Kenya Country office**		**Priority Level: 1**
1. With the shift towards "Delivering as One" UNFPA will need to consolidate its position within UN system and establish a firm niche in reproductive health, population and development gender equality.				
Key action(s)	Deadline	Responsible unit(s)	Annual implementation status updates	
			Status (ongoing or completed)	Comments
1. Active participation in UNDAF development process (DAO)	February 2014	Representative's Office and Programs.		
2. Complete and share Population Situation Analysis (PSA) as part of the UN complimentary analysis and Medium Term Planning for Kenya	October 2014	Programme.		
3. Participation in the UN Joint Programmes	June 2014	Programmes.		
Cluster 1: Strategic recommendation				
Recommendation No. 2		**To KCO**		**Priority Level: 2**
As part of upstream interventions, institutional support and capacity building of pre-service training institutions initiated in the 7th CP should be scaled-up in the 8th CP as an assurance of sustainability in RH, PD and gender training and skills development for service delivery.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Expand direct collaboration with the learning institutions.	December 2014	Representative's Office and Programmes.		
2. Strengthen partnerships with the professional associations to support advocacy on Maternal and New Born Health (MNH), curriculum and policy review.	June 2016	Representative's Office and Programmes.		

Cluster 1: Strategic recommendation				
Recommendation No. 3	**To: KCO**		**Priority Level: 3**	
Under the new UNFPA strategic dispensation and the devolution of service delivery in Kenya, UNFPA has the opportunity to redefine its area of support. UNFPA should assume a more cohesive and holistic approach in programming by concentrating on key programme outputs/activities that are likely to make a difference and demonstrate impact. The selection of the geographical areas needs to be re-defined for effectiveness and efficiency in relation to the new governance structures as well as for easier monitoring and evaluation of programmes.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Participate in the formulation and implementation of the overall UN/Government Of Kenya (GOK) devolution strategy.	June 2017	Representative's office and Programme.		
2. Establish UNFPA specific criteria for selection of geographical areas and partners for programme intervention.	February 2014	Monitoring and Evaluation and Programme.		
Cluster 1: Strategic recommendation				
Recommendation No. 4	**To KCO**		**Priority Level: 2**	
With a draft communication strategy in place and a communication officer at the KCO it is imperative to ensure documentation and sharing of best practices with other development partners and stakeholders as a way of enhancing visibility.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Finalize the draft communication strategy.	June 2014	Communications and Programme.		
2. Document and disseminate good practices.	June 2017	Communications, Monitoring and Evaluation and Programme.		
Cluster 1: Strategic recommendation				
Recommendation No. 5	**To KCO**		**Priority Level: 1**	
To broaden its funding and partnerships base and to innovate its programming, it is recommended that KCO continues to sensitize and dialogue with the private sector on how they can advance MNH in Kenya and continues to strategically reach out to private sector "champions" to develop public private MNH partnerships with.				

Key action(s)	Deadline	Responsible unit(s)	Annual implementation status updates	
			Status (ongoing or completed)	Comments
1. Establish and formalize partnerships with the private sector.	June 2017	Representative's Office.		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 1	**To: KCO**		**Priority Level: 1**	
UNFPA should scale up its support towards humanitarian response in the 8th CP and engage the GOK more on the need to create capacity as well as data bases for rapid assessment and also in profiling emergencies.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Regularize the position of the Humanitarian Officer	December 2013	Representative's Office.		
2. Enhance the national capacity in UNFPA mandated areas for humanitarian response.	June 2017	Programme.		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 2	**To: KCO**		**Priority Level: 1**	
The focus on MDG5 should also address the availability of RH and family planning commodities and equipments in particular LAPMs- noting that one of the constraints for providing family planning was lack of access to commodities. This should be accompanied by an aggressive demand creation programme that builds on the community strategy and structures that are already in place.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Active participation in the annual forecasting and quantification of RH commodities.	June 2017	Programme.		
2. Provide RH commodities to address gaps/needs and during emergencies.	June 2017	Programme.		
3. Support innovative demand creation initiatives.	June 2017	Programme.		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 3	**To: KCO**		**Priority Level: 2**	
Voucher system to support OF should be initiated through discussions between UNFPA, DRH and the Output Based Approach in Aid (OBA) steering committee. This initiative is planned for takeoff as a pilot.				

Key action(s)	Deadline	Responsible unit(s)	Annual implementation status updates	
			Status (ongoing or completed)	Comments
1. Advocate for the inclusion of fistula management within the output based approach voucher system.	June 2014	Programme.		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 4	**To: KCO**		**Priority Level: 1**	
The focus on youth remains paramount, however UNFPA should consider supporting youth within the model of youth friendly services where reproductive health is primary and where UNFPA has comparative advantage.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Scale-up the capacity building for youth within the health sector.	June 2017	Programme.		
2. Advocate for inclusion of youth friendly services within the existing health facilities.	June 2017	Programme.		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 5	**To: KCO**		**Priority Level: 2**	
Considering UNFPAs comparative advantage in the area of SRH, it is crucial that UNFPA provides technical support to the Ministry of Education (especially KIE) on comprehensive sexuality education in the school curriculum				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Establish collaboration with Ministry of Education.	June 2015	Programme.		
2. Advocate for domestication of international guidelines on comprehensive sexuality education.	June 2017	Programme.		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 6	**To: KCO**		**Priority Level: 1**	
There is need to scale up the use of comprehensive RH drop-in centers, other HIV CT initiatives such as moonlighting, outreach and the peer approach in reaching vulnerable groups such as MARPs and SWs; to increase access to SRH/HIV/AIDS services.				

Key action(s)	Deadline	Responsible unit(s)	Annual implementation status updates	
			Status (ongoing or completed)	Comments
1. Scale up access to comprehensive RH services targeting MARPs.	June 2017	Programme		
2. Facilitate integration of services targeting MARPs into the existing SRH, FP and HIV services.	June 2017	Programme		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 7	**To: KCO**		**Priority Level: 1**	
In the planning of the 8th CP it would be prudent to emphasize on conducting baseline survey where there is no data and to emphasize data capture by IPs to facilitate realistic target setting and trend analysis at both MTR and CPE. This could be reinforced as part of IPs core deliverables.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Provide data for baseline and target setting	September 2013	Programme		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 8	**To: KCO**		**Priority Level: 2**	
To increase sustainability and demonstrate impact, it is necessary to enhance support to IPs in the knowledge industry and to invest in research, specialized studies and/or region specific surveys so as to add value and increase dissemination/visibility to the work that UNFPA supports.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Identify and commission thematic studies in UNFPA mandated areas	June 2017	Programme		
2. Support dissemination of the results of UNFPA commissioned and relevant studies	June 2017	Programme		
3. Establish partnerships with research and educational institutions to leverage on-going thematic studies	June 2017	Programme		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 9	**To: KCO**		**Priority Level: 2**	
With regard to support for revitalization of vital registration systems in the focal districts, effectiveness demands that UNFPA focuses more on advocacy than infrastructure development.				

Key action(s)	Deadline	Responsible unit(s)	Annual implementation status updates	
			Status (ongoing or completed)	Comments
1. Advocate for vital registration at national and county levels	June 2017	Programme		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 10	**To: KCO**		**Priority Level: 1**	
To improve overall programme performance of the 8th CP, measures should be urgently put in place to help unearth and resolve the causes of lack of compliance with RBM requirements, especially regarding reporting on results in the 7th CP. Consideration should be given to an urgent review of reporting tools, additional training in RBM and tracking of trainees and their deployment over time.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Assess entire programming and reporting for results	June 2014	M&E and Programme		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 11	**To: KCO**		**Priority Level: 1**	
Gender equality issues are dynamic; hence there is a constant demand for accurate baselines and collection and analysis of sex and age disaggregated data to establish trends, anchor proper mitigation as well as provide effective and efficient support to interventions.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Conduct baseline surveys on GBV and FGM/C in the areas where non exists	December 2014	Programme		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 12	**To: KCO**		**Priority Level: 1**	
There is need to address socio-cultural issues and to advocate for improved infrastructure and adequate resources in line with MDG5 so as not to lose on the gains already made towards addressing GBV and FGM/C. The capacity building efforts for all stakeholders, IPs, beneficiaries and government agencies on gender equality and other gender related issues needs to be continuous.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Advocate at national and county levels for allocation of resources by government to address socio-cultural barriers	June 2017	Representative's office and Programme		

Cluster 2: Recommendations associated with the programme				
Recommendation No. 13	**To: KCO**		**Priority Level: 2**	
There is need to strengthen the referral systems, especially those related to counseling and post 'violation' medical/ psychosocial support, access to justice and safe spaces for the survivors of GBV by getting all actors to engage in constructive dialogue. Increased funding and technical support, especially in DNA and forensic collection/testing of evidence is needed to ensure meaningful support. In addition, follow-up mechanisms of survivors, clinical, psychosocial and legal, as well as lack of structured social safety nets still pose a great challenge to dealing with GBV. The involvement of a wide cross-section of community stakeholders in handling issues of GBV is therefore needed				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Strengthen GBV coordination mechanism and capacity to address the medical, psychosocial, security and legal sectors	June 2017	Programme		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 14	**To: KCO**		**Priority Level: 1**	
Strengthening of existing and creation of new community structures is critical to act as safety nets for girls who escape FGM. This can be done by reinforcing community based structures such as community networks to prevent and respond to GBV and FGM/C and to facilitate community dialogue.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Advocate and build capacity for community structures / networks to act as safety net for girls escaping from FGM	June 2017	Programme		
Cluster 2: Recommendations associated with the programme				
Recommendation No. 15	**To: KCO**		**Priority Level: 2**	
There is need to continue strengthening the close and cordial working relationship between UNFPA/GOK relevant ministries, UN agencies, development partners (donors), IPs (NGOs, CBOs, and FBOs) and communities.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Participate in the coordination networks	June 2017	Programme		

Cluster 2: Recommendations associated with the programme				
Recommendation No. 16	**To: KCO**		**Priority Level: 2**	
The 8th CP should emphasize up scaling of GBVIMS in other public hospitals and enhancement of ownership by MOH, MOPHS, KNBS and MOGSD so as to provide information to aid in programme planning and implementation.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Conduct an assessment for the pilot GBVIMS	June 2014	Programme		
2. Advocacy for integration of GBVIMS into the HMIS for sustainability and to facilitate the scale up	June 2017	Programme		
Cluster 3: Recommendations associated with cross-cutting issues				
Recommendation No. 1	**To KCO**		**Priority Level 1**	
To strengthen and place the M&E system on a firmer evidence-based footing, there is need to carry out a comprehensive evaluation of the CO M&E system.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
Evaluate the CO M&E system	June 2014	M&E and Programme		
Cluster 3: Recommendations associated with cross-cutting issues				
Recommendation No. 2	**To KCO**		**Priority Level 1**	
It is important that the M&E framework for the 8th CP is developed during the design stage of the programme and that the framework is structured to feed adequately into NIMES.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Develop M&E framework together with the 8th CP	June 2014	M&E and Programme		
2. Participate in the formulation and implementation of the overall national M&E framework to link the 8CP to NIMES	June 2017	M&E and Programme		

Cluster 3: Recommendations associated with cross-cutting issues				
Recommendation No.3	**To KCO**		**Priority Level 1**	
The KCO needs to identify, formalize, document and assess the risks and assumptions affecting the CP as part of risk management and also work out mitigating factors so that there is some level of anticipation and preparedness to inform realistic target setting and to support a RBM culture				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
The risks and assumptions likely to affect the 8th country programme should be identified, formalized and documented.	September 2013	M&E and Programme		
Cluster 3: Recommendations associated with cross-cutting issues				
Recommendation No. 4	**To KCO**		**Priority Level 1**	
In recognition of the importance of M&E it would be prudent to strengthen the CO M&E function/desk to manage data capture and to oversee production of reports that inform not only programming within UNFPA but also other stakeholders. In this light the roles and responsibilities of the NPPPs positioned in line ministries or IPs should be clarified so that they are able to effectively monitor and document programme activities.				
Key action(s)	**Deadline**	**Responsible unit(s)**	**Annual implementation status updates**	
			Status (ongoing or completed)	Comments
1. Implement recommendations of M&E assessment (action recommendation # 1)	June 2014	M&E and Programme		
2. Orient IPs on their roles and responsibilities regarding M&E as specified in the UNFPA IP manual	June 2014	M&E and Programme		

ANNEX 2: LIST OF RESPONDENTS/PERSONS INTERVIEWED

Name/ Designation	Organization	Contact
Nairobi		
Dr. Shannaz Sharif *Director MOPHs*	Ministry of Public Health	MOPHS
Dr. Isaak Bashir *Head DRH*	Division of Reproductive Health	DRH
Dr. Pamela Godia *Programme Manager*	Division of Reproductive Health	pgodia@yahoo.com
Mr. James Mwanzia *Chief Economist, MED*	Ministry of State for Planning, National Development and Vision 2030	james_mwanzia2015@yahoo.com
Mr. Kennedy Nyanchiro *Chief Economist, External Resources Dept,*	Ministry of Finance	Ministry of Finance, Nairobi
Mr. Mutunga *Economist*	Ministry of Finance	Ministry of Finance, Nairobi
Ms. Heglar Musyoki *Programme Officer , MARPS*	NASCOP	NASCOP HQs
Dr. Boniface K'Oyugi *Executive Director*	NCPD	NCPD- Nairobi
Mr. Karugu Ngatia *Directorof Programmes*	NCPD	NCPD- Nairobi
Mr. Nzomo Mulatya *Senior Population Officer*	NCPD	NCPD- Nairobi
Mr. Peter Mwangangi *DDO Nairobi West*	Ministry of Planning and Development	Ministry of Planning and Development
Mr. Zachary Mwangi *Acting Director General*	KNBS	KNBS
Mr. Michael Musyoka	KNBS	KNBS
Mrs. Eunice Odongi *NPP Personnel*	NACC	eodongi@nacc.or.ke
Ms. Florence Gachanja *Programme Analyst*	UNFPA	UNFPA Kenya
Mr. John Gicharu *NPPP NGEC*	UNFPA	UNFPA Kenya
Dr. Geofrey Okumu *RH/HIV Specialist*	UNFPA	UNFPA Kenya
Mr. Ezekiel Ngure *Population Analyst*	UNFPA	UNFPA Kenya
Lister Chapeta *Population and Gender specialist*	UNFPA	UNFPA Kenya
Dr. Stephen Wanyee *Assistant Resident Representative*	UNFPA	UNFPA Kenya

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Asman Wesonga *vice/chairperson*	MUMCOP	MUMCOP
Stephen Washika *Community Volunteer*	MUMCOP	MUMCOP
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Agnes Njoga *Field Officer*	Kenya Red Cross Society	KRCS
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Community Members	Community Members- floods victims	Kendu Bay and Nyakach areas
Kisumu/ Kakamega		
Dr. Marete *Obstetrician, gynaelogist*	Kakamega PGH	Kakamega PGH
Dr. Mitei *Obstetrician/Gynecologist*	Nyanza PGH	Nyanza PGH
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ANNEX 3: REFERENCES

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ANNEX 4: TERMS OF REFERENCE FOR THE EVALUATION TEAM

I. INTRODUCTION

The 7th Country Programme (2009-213) of UNFPA support to the Government of Kenya responds to national priorities as articulated in the first Medium Term Plan (MTP) and the United Nations Development Assistance Framework (UNDAF). The UNDAF is based on three priority areas and three crosscutting themes integrated across the priority areas and outcomes. The GOK/UNFPA 7th Country Programme was developed in line with the UNFPA Strategic Plan for the period 2008-2011, which has since been revised and extended to 2013.

The country programme responds to five of the 6 UNDAF outcomes. The programme is guided by the external resources policy of the Government, which specifies its relationship with development partners. The programme was approved for $32.5 million: $25.5 million from regular resources and $7 million through co-financing modalities and/or other, including regular, resources.

UNFPA conducted a country programme evaluation of the Strategic Plan (2008-2011) and based on the outcome launched a Revised Strategic Plan for the period 2012-13. The revised UNFPA strategic plan is the centerpiece for organizational programming, management and accountability for the period 2012-2013. In revising the strategic plan, UNFPA adopted a refined strategic focus, which is designed to direct its work squarely on sexual and reproductive health and reproductive rights, on supporting greater progress towards MDG 5 and towards the ICPD agenda. In order to remain relevant and in line with the adopted refined strategic focus, the 7th Country Programme was re-aligned to contribute to five out of the seven revised strategic plan outcomes:

UNFPA is in the process of working out a new cluster mechanism at the global level, which is an innovative way of thinking, of breaking down silos, of optimizing resources and delivering results. Based on this new thinking two clusters have been established focusing on: (i) Adolescents & Youth, and (ii) Women's Reproductive Health.

The goal of the cluster approach is to change the way UNFPA works in order to maximize results through coherent planning and implementation of capacity building activities and technical support from headquarters and regional offices to the countries.

II. CONTEXT

The goal of the Seventh Country Programme is to contribute to the improvement of the quality of life of the people of Kenya, which will contribute to the First Medium Term Plan (MTP I). MTP I is the Government of Kenya's first operational plan for Vision 2030 for the period 2008-2012. Using capacity-building strategies, the programme was by design intended to build and promote the use of a knowledge base; reinforce advocacy and policy dialogue; expand and strengthen partnerships; and develop systems for improving performance. The Country Programme has also been designed to contribute to the United Nations Development Assistance Framework (UNDAF) outcomes, while ensuring linkages with the UNFPA Strategic Plan.

The country programme is delivered in collaboration with other UN agencies through joint programming in line with the UNDAF and in the spirit of "Delivering as One UN". The potential areas for joint programmes and joint programming indentified during the design include: (a) HIV/AIDS; (b) data collection and development of databases; (c) gender equality; (d) young people's health and development; (e) monitoring of MDGs; (f) access to reproductive health; (g) FGM/C; (h) SGBV; and (i) humanitarian response.

The Country Programme was developed to contribute to two UNDAF outcomes, 4 CP outcomes and 8 outputs, categorized by each of the three programme component, and which were expected to be deliverable by 2013, which include the following:

Reproductive Health and Rights

UNDAF Outcome

1. Measurably reduced risks and consequences of conflict and natural disaster
2. National HIV response is delivering sustained reduction in new infections, scaled up treatment, care, support and effective impact mitigation

CP Outcomes:

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

CP Outputs:

1. Maternal and newborn health services, including services to prevent and manage fistula, are available, especially for young people and vulnerable groups in selected districts
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
3. Increased availability of high-quality services to prevent HIV and sexually transmitted infections, especially for women, young people and other vulnerable groups

Population and Development

UNDAF Outcome:

1. Strengthened institutional and legal frameworks and processes that support democratic governance, transformation, accountability, respect for human rights and gender equality

CP Outcome:

1. Population dynamics issues and their inter-linkages 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.

CP Outputs:

1. Improved coordination, monitoring implementation and evaluation of gender-responsive population and reproductive health policies and programmes
2. Improved systematic collection, analysis and dissemination of quality gender-sensitive population and reproductive health data

Gender Equality

UNDAF Outcome:

1. Strengthened institutional and legal frameworks and processes that support democratic governance, transformation, accountability, respect for human rights and gender equality

CP Outcome:

1. Gender equality, the empowerment of women, and realization of human rights enhanced.

CP Outputs:

1. Increased access to accurate and appropriate information and services on sexual and gender-based violence including emergency and post-emergency situations
2. Enhanced institutional mechanisms to reduce and respond to gender-based violence and discrimination, particularly among marginalized populations and during humanitarian crisis
3. Improved advocacy for women and adolescent girls' reproductive rights, male participation in reproductive health and elimination of harmful practices, particularly FGM/C

The Ministry of Finance oversees the national execution of the programme as Government Coordinating Authority, while at the operation level; the programme is coordinated by the Ministry of State for Planning, National Development and Vision 2030 through the National Council for Population and Development (NCPD).

III. OBJECTIVES AND SCOPE OF THE EVALUATION

The purpose of this end line evaluation is to assess the programme performance; determine the factors that facilitated or hindered achievement, and document the lessons learned from the past cooperation that could inform the formulation of the 8th Country Programme of UNFPA support to the Government of Kenya.

The major objective of this evaluation is to assess achievements, identify the factors that facilitated or hindered achievement, and to compile lessons that would inform development of the 8th CP. Findings of this evaluation will also provide input to the UNDAF evaluation. Specific objectives are:

1. To assess GOK/UNFPA 7CP's performance at the various levels of results chain (activities, CP outputs, CP outcomes, UNDAF outcomes, UNFPA SP outcomes, MTP outcomes)
2. To assess the extent to which the implementation framework (Partnership Strategy; Execution/Implementation arrangements; Human Resources; Resource Mobilization; Cash Transfer Modalities; and Monitoring & Evaluation) enabled or hindered achievement of the results chain i.e. what worked well and what did not work well
3. To assess the extent to which the programme is aligned to the Government priorities, harmonized with MDGs and supportive of new Aid Modalities
4. To identify success stories, if any, and document the lessons learnt in programme implementation, management and coordination.

Time period – The 7th Country Programme Evaluation will factor in, the recommendations made in the final evaluation of the 6th country programme and much more substantively, programme implementation from 2009 to the date of submission of the final report.

Geographical regions – The evaluation will have impetus on the programme focus districts, namely Nairobi West, Kilifi, Naivasha and Migori. In addition to the four programme focus districts, the evaluation will consider all other programme interventions that are broad based with a national perspective, which include but are not limited to policies, strategies, laws and legislation. Programmes such as data collection, and other targeted interventions such as FGM/C will also be evaluated.

Programme aspects – The evaluation will focus on all the programme aspects contained in the approved 7th Country Programme Document (CPD), which have been elaborated in the Country Programme Action Plan (CPAP)

Funding source – The evaluation will focus on interventions supported with both regular (core) resources from UNFPA as well as trust funds from donors such as DFID, SIDA, and Norway, among others.

IV. EVALUATION QUESTIONS

The key evaluation questions will include but are not limited to the following:

Relevance

- To what extent is the 7CP programme consistent with beneficiaries requirements, partners', country needs, UNFPA's policies and strategies; as well as global priorities
- Is the programme/project design in line with: national needs and policies; priorities of the programme/project stakeholders and target groups; the goals of the ICPD Program of Action and the MDGs; and
- Is there synergy or complementarity between UNFPA's intervention and that of other development partners?

Effectiveness

- How did inputs and activities lead to outputs and outcomes?
- To what extent did the outputs contribute to the achievement of the outcomes and, the degree of achievement of the outcomes?
- What was intervention coverage – were the planned geographic area and target group successfully reached?
- To what extent has coordination at various levels made it possible for realization of the outputs and create synergies/complementarities in the country programme as well as each of the three programme components?
- To what extent have the monitoring and evaluation mechanisms in place in the Country Office and as implemented by the IPs been focused on the results and helped to improve them?

Efficiency

- Were the most cost-saving methods considered?
- In what proportions have the resources been used to achieve the outputs in the most cost-efficient manner?
- What was the quality of outputs achieved in relation to the expenditure incurred, resources used?
- What was the timeliness of inputs (personnel, consultants, travel, training, equipment and miscellaneous costs); timeliness of outputs?
- Were resources spent as economically as possible: could different interventions have solved the same problem at a low cost?
- Could more results have been produced with the same resources?

Sustainability

- Did the programme/project have/is it likely to have lasting results after programme/project termination?
- Are stakeholders ready to continue supporting or carrying out specific programme/project activities; replicate the activities in other regions or sectors of the country; adapt programme/project results in other contexts?
- Did programme design include strategies to ensure sustainability? Were any of these strategies on sustainability used in the course of programme implementation?
- In line with results based approach, did the programme solicit the participation of the beneficiaries at all levels of implementation?

Strategic Alignment (Corporate Dimension): -

- To what extent was the actual implementation of the Country Programme aligned to the UNFPA corporate mandate as set out in the Strategic Plan?

Strategic Alignment (Systemic Dimension)

- To what extent was the UNFPA Country Programme aligned to the UN system in the country?

Responsiveness

- To what extent was the programme able to respond to changes in national priorities and to additional requests from national counterparts, as well as to shifts caused by major external factors and the evolving country context without prejudice to development results?

Added Value (Stakeholder's perception about UNFPA in the Country)

- How do the national counterparts and other development actors perceive, recognize and recall UNFPA's performance in the country?
- What is the perceived value of UNFPA as a development partner in the country i.e. what would the country lose if UNFPA did not have a presence in Kenya?
- What is UNFPA perceived to do best by relevant development partners?

Impact

- Have long-term results been achieved or are they likely to be met?
- What has happened (or is likely to happen) as a consequence of UNFPA's efforts (directly or indirectly, intended or unintended)?

V. METHODOLOGY AND APPROACH

In general, the methodology will include collection of both quantitative and qualitative data and an in-depth analysis to reach concrete conclusions. Generally, the Evaluation Team will:

- Prepare an inception/design report, which will include an elaborate evaluation methodology framework and a plan for assuring the quality of the products. The inception/design report will be discussed with and agreed on by the evaluation management committee.
- Review available documentation to obtain a general overview of programme design and progress
- Participate (and where possible facilitate) in the UNFPA Programme Policies and Procedures Capacity Building Workshop (the workshop will among others cover modules on How to Conduct a Country Programme Evaluation – a UNFPA perspective)
- Hold meetings with and interview relevant officials of the UNFPA Kenya Country Office; key Government of Kenya officials (including Programme Component Managers); relevant UN Agency focal points; and relevant Development Partners (including UN Agencies)
- Interview key persons associated with the programme; i.e. the Implementing Partners;
- Visit identified programme sites to, among others, assess physical conditions of the facilities, equipment and supplies; and to interview programme beneficiaries
- Collect information/data through key informant interviews, focus group discussions, etc, to comprehensively address all the evaluation questions
- Conduct data analysis and prepare a report that responds to the evaluation questions and in accordance and as per the annexed " structure of the final report" template
- Participate and facilitate a Stakeholders Meeting to validate the Evaluation Report

- Brief and consult with the Evaluation Manager and the Evaluation Management Committee on a regular basis
- Incorporate management response in the Management Response Template (attached) and annex the same to the final report

Data collection methods will include but not necessarily limited to

- Desk review and content analysis of key documents
- In depth interviews with key stakeholders (Implementing Partners, Beneficiaries, UNFPA CO staff, Development Partners, etc)
- Participatory and non participatory observations (visits to selected project sites)
- Focus Group Discussions with Project partners and beneficiaries

VI. EVALUATION PROCESS

The evaluation process will entail preparation of an inception/design report that will comprehensively cover the design of the evaluation; field data collection and analysis; report writing; preparation of a management response; finalization of report; dissemination of the final report; and follow up on the implementation of the recommendations. The findings and recommendations arising out of the CPE will inform the design of the 8th Country Programme, which will be drafted during the year. The Evaluation Team will work in close consultation with the Evaluation Management Committee in each of the aforementioned phases and steps of the entire evaluation process.

VII. EXPECTED OUTPUTS

The following outputs/products are expected by the end of the consultancy, which is expected to take 35 working days:

i. Inception report that is acceptable to the EMC (maximum 20 pages)

ii. A debriefing presentation at the end of the field phase

iii. Draft end of 7th country programme evaluation report, having completed the field work (must include a management response as an annex and should be in accordance with requirements of the UNFPA Handbook on How to Conduct a Country Programme Evaluation)

iv. Final 7th country programme evaluation report incorporating comments from the EMC with a management response annexed to the report (Maximum 50 pages plus annexes)

To facilitate the delivery of the aforementioned outputs, the fees for the consultancy will be based on the UN regulations and in consultation with the UNFPA Country Office. In addition, the consultants will be provided with the necessary administrative and logistical support to enable them deliver on the expected outputs. UNFPA will apply performance based principles to the management of the evaluation contract, in which case the contract sum will be paid in installments pegged to achievements of milestones as follows:

- 10% initial deposit, which covers up to the delivery of inception report that is acceptable to the EMC;
- 20% second payment to cover field work phase up to delivery of a comprehensive draft report/accountability;
- 70 % payable on receipt of a final report, which must be preceded by a stakeholders meeting with participation/ facilitation of the consultants

VIII. WORK PLAN

The Country Programme Evaluation is expected to take 35 working days from the date of signing the contract. The 35 working days will be spread over a period of about 3 months during the period June-August, 2012.

GOK/UNFPA 7TH COUNTRY PROGRAMME EVALUATION (CPE)													
	2011	2012											
	Dec-11	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Commission end of country programme evaluation during Annua Programme Review Meeting (with key stakeholders)													
Establish Evaluation Management Committee with leadership of GOK													
Draft Terms of Reference for the CPE with inputs from KCO team													
Submit TOR to ARO for review and inputs (and incorporate comments)													
Submit TOR to GOK and request that EMC be convened													
KCO briefs EMC and presents draft TOR for review and consensus building													
Revise Terms of Reference with inputs from EMC and ARO													
Recruit members of the Evaluation Team													
Brief the Evaluation Team (by KCO)													
Evaluation Team prepare inception report and submit to UNFPA and EMC													
ET present inception report to EMC and build consensus													
KCO organizes a UNFPA Programme Policies and Procedures Workshop where KCO and IPs make presentation of the programme results, facilitating and constraining factors, lessons learned to ET													

GOK/UNFPA 7TH COUNTRY PROGRAMME EVALUATION (CPE)													
	2011	2012											
	Dec-11	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Evaluation Team conduct desk review													
Data Collection by Evaluation Team (M&E Officer and EMC member accompanies ET to the field for data collection)													
ET prepares CPE draft report and submits to UNFPA													
UNFPA shares report with EMC. A meeting is convened for ET to present report to EMC and discuss the draft.													
EMC submits consolidated comments on the draft report to Evaluation Team													
Evaluation Team revises report based on comments and submits to UNFPA and EMC													
UNFPA KCO submits draft report to SRO-J and ARO for quality assurance													
Evaluation Team receives feedback from EMC as well as UNFPA CO/SRO-J/ARO UNFPA ARO; and revises the report													
GOK and UNFPA convenes Stakeholder Meeting to validate CPE report													
Evaluation Team receives feedback from Stakeholders, finalizes the report and submits to EMC for management response													
EMC prepares a management response on the CPE recommendations and submits to Evaluation Team													
Evaluation Team annexes the management response to the final report and submits as final													
UNFPA KCO Uploads final CPE report in Evaluation folder													

GOK/UNFPA 7TH COUNTRY PROGRAMME EVALUATION (CPE)													
	2011	2012											
	Dec-11	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Conduct CPE Dissemination Workshop and utilize the Evaluation Report to inform formulation of the 8CP													

IX. COMPOSITION OF THE EVALUATION TEAM

UNFPA is fielding a team of three independent consultants recruited nationally and charged with the responsibility of preparing the end-of-country-cycle evaluation report (CPE) and/or other technical papers as may be required. The consultants will be responsible for conducting the final evaluation of the country programme, with both retrospective and prospective elements. The retrospective part will evaluate the programme's achievements and challenges in implementing the country programme from 2009-2011 and examine the implications of the programming in the context of the refined UNFPA focus. Given the retrospective element of this evaluation, the consultants will focus on three key areas, namely:

i. Sexual and Reproductive Health

ii. Population Dynamics

iii. Gender Equality and Human Rights

Consultant for Sexual and Reproductive Health:

At least a Master's Degree in Public Health, or any other relevant field; extensive national and international experience in monitoring and evaluation of Reproductive Health programmes. Experience on evaluation of UN supported programmes will be an added advantage.

Consultant for Population Dynamics:

At least a Master's Degree in a Population related subject, or any other relevant field; extensive national and international experience in monitoring and evaluation of programme population and development programmes. Experience on evaluation of UN supported programmes will be an added advantage.

Consultant for Gender Equality and Human Rights:

At least a Master's Degree in Gender and Development Studies, or any other relevant field; extensive national and international experience in monitoring and evaluation of Gender Programmes; Experience on evaluation of UN supported programmes will be an added advantage.

The Team Leader (TL) of the consultants will be one of the three consultants and will be charged with the responsibility of coordinating the activities of his/her co-consultants and assess the extent to which the various outputs contribute in meeting the aims of the GOK/UNFPA 7th Country Programme and the Government's overall population objectives as they relate to the ICPD and ICPD+5 goals. In preparing the final report, the Evaluation Team will consider the prospective elements of the programme and the need to focus on sexual and reproductive rights, and accelerating progress towards MDG 5 and towards the ICPD agenda. The Team Leader must therefore be very clear on both the retrospective and prospective needs of the UNFPA supported programmes.

The Team Leader must, in addition to the aforementioned, be able to demonstrate a very clear of both the retrospective and prospective needs of the UNFPA supported programmes. He/She should have solid understanding of evaluation methodologies, and/or a proven expertise of research in a social science relevant for the evaluation, in particular national monitoring and evaluation systems. Demonstrated capacity for strategic thinking and policy advice are essential. Familiarity with UNFPA or United Nations operations will be an advantage.

All must be committed to respecting deadlines of delivery outputs within the agreed time-frame. They must also be able to work in a multi-disciplinary team and multicultural environment.

X. MANAGEMENT AND CONDUCT OF THE EVALUATION

Main Oversight Activities of the Evaluation Management Committee

- Approve of TOR
- Ensure consensus on evaluation design, evaluation recruitment, roles and responsibilities of implementing partners;
- Select and debrief Evaluation team
- Organize technical support and provide continual feedback during the evaluation process
- Approve inception report and final evaluation budget
- Monitor progress and quality of evaluation activities
- Review and comment on drafts
- Arrange meetings with key stakeholders to discuss drafts of the evaluation reports;
- Verify the quality, integrity and relevance of the final evaluation report Approve evaluation reports
- Facilitate access to documentation and key informants
- Ensure logistical and administrative support arrangements
- Ensure discussion of evaluation findings and recommendations with all major stakeholders and agreement on a follow-up plan of action
- Assess performance and approve payments to evaluators
- Disseminate and follow up to evaluation finding

Main Oversight Activities of an Evaluation Manager

- Support the Evaluation Management Committee meetings
- Lead development of the TOR and the management response.
- Manage the evaluation budget and ensure logistical and administrative support
- Facilitate access to background documents
- Upload evaluation TOR and final report into UNFPA central repository
- Provide ongoing feedback for quality assurance during the preparation of the design report and the final report

XI. THE EVALUATION AUDIENCE

The evaluation audience will include but will not be limited to the various target groups in the population and will pay specific attention to adolescents and youth; and women of reproductive age; given the prospective cluster approach to programming. The audience will further include Implementing Partners of the Programme; Development Partners and other key stakeholders in Population and Development.

The primary users of the evaluation are the decision-makers within the Government of Kenya; UNFPA and the Executive Board; Development Partners; and all key stakeholders, particularly the Implementing Partners.

XII. BIBLIOGRAPHY AND RESOURCES

The following documents will, among others be shared with the consultants:

1. GOK/UNFPA 7th Country Programme Document
2. GOK/UNFPA 7th Country Programme Action Plan
3. GOK/UNFPA 7th Country Programme Monitoring and Evaluation Plan
4. GOK/UNFPA Mid Term Review of the 7th Country Programme Report
5. UNFPA Strategic Plan (2008-2011)
6. Revised UNFPA Strategic Plan (2012-2013)
7. Re-aligned 7th Country Programme Results and Resources Framework
8. Final Evaluation of the GOK/UNFPA 6th Country Programme
9. United Nations Development Assistance Framework (2009-2013) Kenya
10. Kenya Vision 2030
11. First Medium Term Plan (MTP I) of the Kenya Vision 2030
12. Government of Kenya Sector Plans
13. UNFPA Strategic Plan
14. Annual Work Plans for Implementing Partners (2009, 2010, 2011, 2012)
15. Quarterly and Annual Progress and Financial Reports from Implementing Partners (2009, 2010, 2011)
16. Audit Reports for all Implementing Partners (2009, 2010, 2011)
17. Reports of Bi-Annual and Annual Programme Review Meetings (2009, 2010, 2011)
18. Minutes of Joint Programmes, Working Groups, etc
19. Field Monitoring Reports
20. Final country programme evaluation report of the 6th Country programme
21. Country Office Annual Reports (COARs) to the UNFPA Executive Director
22. Thematic Evaluation of UNFPA's Support in Maternal Health including the Maternal Health Thematic Fund's Contribution – Kenya Country Case Study Note
23. MTP Progress Reports
24. The Multilateral Organisation Performance Assessment Network (MOPAN)
25. Handbook to "How to Design and Conduct a Country Programme Evaluation at UNFPA"

APPENDICES

Appendix 1: List of Implementing Partners in RH

No	Implementing partner	Area of focus	Current
1	DRH	Output 1 Output 2 Output 3	Output 2
2	DHMTs Kilifi Migori Naivasha	 Output 1 Output 2 Output 3	Output 2
3	NASCOP	Output 3	
4	MOMS	Output 1	
5	NACC	Output 3 – RH Output 2 - Gender	
6	MOYAS	Output 2	Output 2
7	International Centre for Research in Reproductive Health (ICRH)	Output 2 Output 3	
8	Family Health Options	Output 3	
9	City Council of Nairobi, West	Output 1 and Output 3	
10	MUMCOP	Output 2 and Output 3	Output 2
11	PCEA Church Naivasha	Output 2	
12	CDN- Nakuru	Output 2	
13	Coast Development Authority	Output 2	
14	Council of imams and preachers of Kenya	Output 2 Output 3	Output 2
15	Kenya Red Cross Society	Output 1	
16	Marie Stopes Kenya	Output 1 Output 2	

Appendix 2. DRH Distribution List of RH Equipment Supported by UNFPA 2012

Equipment	Quantity
Obstetric Fistula Kits	555 *(2012);* 200 *(2011)*
Delivery beds	30
Midwifery Kits	210
Ambu bags	100
Kidney dishes	100
Galli pots	100
Speculums (cuscos)	100
Sponge holding forceps	100

Appendix 3. Formula for Calculating Efficiency

This ratio is an objective function that a DMU tries to maximize.

Subject to:

$$\max h_o(u,v) = \sum_r u_r y_{ro} / \sum_i v_i x_{io}$$

$$\frac{\sum_r u_r y_{ro}}{\sum_i v_i x_{io}} \leq 1, for j = 1, \ldots, n$$

$$u_r, v_i \geq 0 \; for all and r$$

Where:

u 's and the v 's are variables or weights that are attached to each producer's inputs and outputs so as to solve the problem;[i]

y_{ro} 's and x_{io} 's are the observed output and input values, respectively, of the DMU to be evaluated.

Appendix 4a.Contraceptive Availability and Stock-outs in Migori District

Contraceptive Stock-outs during the 7thCP Period 2009- 2012

Relevant Months/ Period*	2009	2010	2011	2012
January	No stock out	Implants, male & female CDs & EC	DMPA, Female CD & Implants	No stock out
February	No stock out	Implants, male & female CDs & EC	DMPA, Female CD & Implants	No stock out
March	No stock out	Implants, male & female CDs & EC	DMPA, Female CD & Implants	No stock out
April	No stock out	Implants, male & female CDs & EC	DMPA, Female CD & Implants	No stock out
May	No stock out	Male & female CDs, COCs & implants	DMPA, Female CD & Implants	No stock out
June	No stock out	Male & female CDs, COCs & implants	DMPA, Female CD & Implants	No stock out
July	Implants	No stock out	No stock out	DMPA & implants
August	Implants	No stock out	No stock out	DMPA & implants
September	Implants	No stock out	No stock out	DMPA & implants
October	implants, male & female CDs	Implants	No stock out	No stock out
November	implants, male & female CDs	No stock out	No stock out	No stock out
December	implants, male & female CD	No stock out	No stock out	No stock out

Key: DMPA- Injection Depo provera, CD – condom, EC –Emergency contraceptives, COCs – Combined oral contraceptives

Appendix 4b: Contraceptive Availability and Stock outs in Nairobi West District

2009 Contraceptives Stock-outs

Contraceptives	Months of Stock Outs	No of M
Combined Oral Contraceptives	January	1
Progestin Only Pills	May, June ,July Aug, Sept & December	6
Emergency Pills	Jan ,Feb, Mar, April, May, June, July August & September.	9
Injectable –Depo Provera	July, Aug, Sept, Nov & December	
Implants - Jadelle	Jan, Feb, Mar, April, May, June, July, Aug, Sept, Oct, Nov & Dec	12
Implants – Implanor	Jan, Feb, Mar, May, June, July, Aug, Sept, Oct, Nov & December	11
I.U.C.D	Jan, Feb & March	3
Male Condoms	January	1
Female Condoms	Jan, Feb, Mar, April, May, June, July Aug & September	9
Cycle Beads	January- December	12

2010 Contraceptives Stock-outs

Contraceptives	Months of Stock Outs	No of M
Combined Oral C	No Stock outs	Nil
Progestin Only Pills	May	1
Emergency Pills	No Stock outs	Nil
Injectable –Depo Provera	Jan, May & December	3
Implants - Jadelle	April, May, Oct, Nov & December	5
Implants – Implanor	Jan, Feb, Mar, April, May June, July, Aug, Sept, Oct Nov & Dec	12
I.U.C.D	August	1
Male Condoms	July, Aug, Sept, Oct, Nov & Dec	6
Female Condoms	Mar, April, May, June, July, Aug Sept ,Oct ,Nov & December	10
Cycle Beads	January - December	12

2011 Contraceptives Stock-outs

Contraceptives	Months of Stock Outs	No of Months
Combined Oral C	Sept	1
Progestin Only Pills	No Stock outs	Nil
Emergency Pills	Feb, Mar, April, May, June &July	6
Injectable –Depo Provera	Jan, Feb, June & July	4
Implants - Jadelle	Jan, Feb, Mar, April, May, June &July	7
Implants – Implanor	Jan, Feb , Mar, April, May, June, July, Aug, Sept & Oct	10
I.U.C.D	No Stock outs	Nil
Male Condoms	January	1
Female Condoms	April, May, June, July, Nov & December	6
Cycle Beads	January- December	12

2012 Contraceptives Stock-outs

Contraceptives	Months of Stock Outs	No of Months
Combined Oral C	No Stock outs	Nil
Progestin Only Pills	No Stock outs	Nil
Emergency Pills	Feb, Mar, April, May, June, Aug, Sept, Oct, Nov & December	10
Injectable –Depo Provera	June	1
Implants - Jadelle	No Stock outs	Nil
Implants – Implanor	No Stock outs	Nil
I.U.C.D	No Stock outs	Nil
Male Condoms	Sept ,Oct, Nov & December	4
Female Condoms	Jan, Feb, Mar, April, May, Oct, Nov & December	8
Cycle Beads	January - December	12

Appendix 5: Major Activities, Indicators, Baseline, Targets and Achievements for RH Output 1

Major activity	Indicator	Baseline 2009	Target 2012	Achievement 2012	Target 2013	Over/Under achievement
Strengthening essential obstetric care and community midwifery (CM)	% sites offering BEOC No of skilled CM recruited, updated and trained No facilities upgraded to provide Fistula services	District specific 45 (15 per district) 8	District specific 315[9] (90 per year) 14	**See Fig. 14** **143** **1z1r** **8 PGHs** **6 DHs**	**See Fig. 14** 405 16	**See Fig. 14** -172 Target achieved
Prevention and Management of Obstetric Fistula	Number of[10] obstetric fistula clients successfully operated	300	1200	**705**	1500	-795
	% fistulae survivors re-integrated into community	50% of those operated	50% of those operated	**39% (275 out of 705)**	50% of those operated	-11%
Strengthening Reproductive Health commodity security	WRA receiving FP commodities A functional LMIS % SDPs in designated districts reporting stock-outs	District specific Not functional 42%[11]	District specific Fully functional LMIS 18%	**See graph on new users of FP per district** **CMU no-longer in operation- Dhis2 in place** **Information available for Migori and NW in months(appendix 4a&4b)**	Fully functional LMIS 10%	Replaced by FP SMS reporting system in July 2012
Supporting RH needs in humanitarian response situations	No. of RH focal points trained in MISP	50	450	**215**	600	**-235**[12]
	No. of Provincial and target district hospitals supplied with emergency kits	-------	8 Provincial hospitals (PH) 4 district hospitals (DH)	**8 PH** **4 DH**	**8 PH** **4 DH**	

[9] The 315 figure is cumulative to include 45 at baseline

[10] Though stated as an output indicator, it should also be stated as an indicator to show the no. of OF cases operated upon

[11] Values such as baseline values in the tracking tool are different from those in the annual targets M&E framework. The tracking tool is a revised version of the M&E framework

[12] In 2010/11 KRC had targeted training 200 RH focal persons on MISP but all trainings were cancelled and funds diverted to emergency response during floods

Major activity	Indicator	Baseline 2009	Target 2012	Achievement 2012	Target 2013	Over/Under achievement
Improve access of young people to integrated SRH and HIV prevention services	No. of national and district development plans adequately in cooperating ASRH&D issues	-----	National (1) District (4)	**National (1)** **District (4)**	National (1) District (4)	
	No. of target districts with functional youth centers providing a minimum package of YFS	----	4	**4- Established and only 2 functional (NW and Naivasha)**	4	-2

Appendix 6: Major Activities, Indicators, Targets and Achievements for RH Output 2

Major Activity	Indicators	Baseline 2009	Target 2012	Achievement 2012	Target 2013	Over/Under achievement
Engaging communities to change negative socio-cultural norms and practices affecting SRH and transmission of HIV	No of IPs implementing BCC	3	13	10		-3
Advocacy for the Prevention and Management of Obstetric Fistula	No of Clients referred	150	600	258(MUMCOP, CDN and CIPK)	750	-342
Revitalization of Family planning	Number of community health extension workers/ Community midwives providing FP information and services	24	96	143	120	+47

Appendix 7: Major Activities, Indicators, Targets and Achievements for RH Output 3

Major Activities	Indicators	Baseline 2009	Target 2012	Achievement 2012	Target for 2013	Over/Under-Achievement
HIV prevention, information, skills and service for young people	No of health institutions (sites) providing YFS to prevent HIV and STIs	-	4	**4**		
	Number of young people and persons Most at Risk (married/discordant couples/ CSWs, MSM receiving comprehensive info& services to prevent HIV&STI per year	15,000 per year	60,000	**185,312**	75,000	+ 110,312
Comprehensive condom programming	Existence of a condom strategy and policy	-	**Condom policy in place**	**1**	Condom policy in place	-
	No. of condoms distributed	4 million	**16 m**illion per year	**152 million (12million per month in 2011)**	20 million	132million Given extension of program to 2013 the target is likely to be surpassed
	No of condom dispensers installed	100	700[13]	**200 (2011) (hotspots)**	900	
	New youth friendly centers providing male and female condoms	-	4	**2 (Nairobi and Migori)**		2
Scaling up HIV and STI prevention skills and services	% of mothers attending ANC counseled and tested for HIV (PMTCT)					
Reducing vulnerability in the context of sex work	No of young people, persons most at risk (CSW) receiving comprehensive HIV/STI services	200	800	**6,847**	1,000	+5,847
Behavior change communication for HIV prevention	No IPs implementing BCC strategies	3	13	**10**		-3

[13] Figures are cumulative for each year

Appendix 8: Major Activities, Indicators, Baseline, Targets, and Achievements for Gender Equality Output 1

Strategy	Indicator (s)	Baseline 2009	Target 2012	Key Achievement (s)	Status of Achievement (s) 2012
G1 A: **Support the promotion of gender equality through advocacy and community involvement including participation of males**	Existence of database on female and male SGBV survivors	No database	Web-based database in place	Website on GBV in place; website hosts GBV incidence database and GBV discussion forums www.gbvkenya.org	Target achieved
	Number of community networks whose capacity have been strengthened on gender equality	Nil	4	**4** district networks/ working groups have been established in the focus district, chaired and coordinated by the District Gender and Social Development Officer (MOGSD), whose capacities have been strengthened.	Target achieved.
G1B: **Lobby for the enactment of gender responsive legislation**	Number of key parliamentary committees sensitized on gender and international human rights instruments	Nil	4 (Planning, Health, Gender & Youth)	**6** parliamentary committees were sensitized.	Target surpassed by a margin of +2
G1C: **Sensitize community leaders**	Number of SGBV committees/ networks established & sensitized on SGBV including HIV/AIDS issues in selected districts	Nil	6	Education forums of **6** Council of Elders Committees from Kisii, Meru, Pokot, Il Chamus and Kuria, and Tana Districts (who are all men), on gender equality issues, including the need to abandon FGM/C **5** Public declarations against FGM/C by the five Council of the Elders	Target achieved

G1 D: **Enlisting the support and participation of faith-based organizations in promoting gender equality**	Number of FBOs participating in promoting gender responsive programme in the selected district	Nil	5	5 FBOs that include: PCEA, Christ is the Answer (CITAM), Kenya Assembly of God, Seventh Day Adventists and SUPKEM	Target achieved. Educational forums further produced a National Christian Network to advocate for gender related issues

Appendix 9: Major Activities, Indicators, Baseline, Targets, and Achievements for GE Output 2

Strategy	Indicator (s)	Baseline 2009	Target 2012	Key Achievements	Status of achievement (s) 2012
G2 A: **Providing supportive services to survivors of Gender-Based Violence strategy**	Existence of a database of existing service providers in target districts	No database	4	Mapping of service providers in the **4** focus district, policy brief in place **139** service providers trained on FGM/C	Target achieved
G2 B: **Strengthening the capacity of institutions, such as the national gender machinery, police and the judicial system, for the implementation and enforcement of gender responsive laws and policies**	Number of law enforcement agents with skills to handle SGBV related issues	Nil	1,000 (200 annually)	**1, 400** law enforcement agents trained	Target surpassed
	Existence of a report on an assessment of SGBV services	None	Report on assessment of GBV services in place	Assessment report on GBV services in place Policy briefs in place and shared with relevant stakeholders	Target achieved
G2 C: **Supporting protective services or social safety nets to reduce Gender-Based Violence**	Number of community networks supported in selected districts	1	5 (increase of 4)	Working groups established in the **4** select districts consisting of community watch groups, GBV working groups, FGM networks and Court Users' committees.	Target surpassed

Strategy	Indicator (s)	Baseline 2009	Target 2012	Key Achievements	Status of achievement (s) 2012
G2 D: Mainstreaming women's rights and gender equality into national legislation, policies, programmes and budgets	Existence of Gender Responsive Guidelines, frameworks, policies and Acts.	None	Responsive Guidelines in place	The Gender Responsive Budgeting guidelines finalized (awaiting adoption by government) The establishment of the National Response and Prevention framework on GBV and its National Action Plan for the co-ordination of GBV implementation. National Action Plan for Gender Mainstreaming in HIV and AIDS and the National Training Curricular on Sexual and GBV also supported by the 7th CP. FGM Law in place FGM Policy developed **300** officers trained in gender mainstreaming in line ministries Commission on revenue allocation influenced for resource allocation for gender equality by NGEC	Target achieved
	Number of projects/ programmes in selected districts involving men and boys on SRHR	None	20	- 7 IPs and affiliate organizations in the focus districts: Ministry of Gender and Social Development, FIDA Kenya, National Gender and Equality Commission (NGEC), Maendeleo ya Wanawake (MYWO), Women Empowerment Link (WEL), Kenya Women Judges Association (KJWA) and Kenya Women Parliamentarians Association	Target likely to be achieved within 7th CP

Appendix 10: Major Activities, Indicators, Baseline, Targets, and Achievements for GE Output 3

Strategy	Indicator (s)	Baseline 2009	Target 2012	Key Achievements	Status of Achievement (s) 2012
G3A: **Supporting activities aimed at enactment of laws that address harmful practices, particularly FGM and early marriage**	Number of policy makers including parliamentarians sensitized on harmful cultural practices including FGM	20	90 (increase of 70)	**155** policy makers educated on harmful cultural practices including FGM **7** parliamentary committees.	Target surpassed
G3 B: **Support alternative rites of passage and appropriate safety nets in selected districts**	Number of girls who undergo ARP in project sites	1,000	2,500 (300 annually, increase of 1500)	**586** girls have undergone ARP **35** girls have refused to undergo FGM **13** boys have become champions on FGM	Target likely to be achieved in the 7th CP
G3 C: **Promote gender-friendly socio-cultural environments through Media Campaigns**	Frequency of media reports on gender issues	1 Nil	12 60 (1 feature per month)	- **402**	Target surpassed

NATIONAL COUNCIL FOR POPULATION AND DEVELOPMENT (NCPD)

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