COUNTRY REPORT

KENYA

EVALUATION OF UNFPA SUPPORT TO MATERNAL HEALTH

Mid-Term Evaluation of the Maternal Health Thematic Fund

EVALUATION BRANCH
Division for Oversight Services

New York, October 2012

UNFPA

Evaluation of UNFPA Support to Maternal Health
Mid-Term Evaluation of the Maternal Health Thematic Fund

COUNTRY REPORT: KENYA

Kenya Country Office

Duah Owusu-Sarfo, Representative

Field Team

AGEG Consultants eG	
Field Team Leader (Thematic Evaluation Team Leader)	Dr. Corinna Reinicke
Evaluator Reproductive Health	Joyce Olenja
Field support	Mumbi Wanjiku Mwakio
Evaluation coordinator	Martina Jacobson Miriam Amine

E-mail: evb@unfpa.org Phone number: +1 212 297 2620

http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE

Layout and design: uPwelling.net

EVALUATION OF UNFPA SUPPORT TO MATERNAL HEALTH

Including the contribution of
the Maternal Health Thematic Fund

EVALUATION BRANCH
Division for Oversight Services
New York, October 2012

Table of Contents

List of Figures

List of Tables

List of Acronyms

AWP	Annual work plan
BCC	Behavior change communication
CAP	Consolidated appeal process
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CDN	Catholic Diocese of Nakuru
CHEW	Community Health Extension Worker
CIPK	Council of Imams and Preachers of Kenya
CP	Country programme
CPAP	Country programme action plan
DAC	Development Assistance Committee
DANIDA	Danish International Development Agency
DFID	UK Department for International Development
DHS	Demographic and Health Survey
DMOH	District Medical Officer of Health
DRH	Department for Reproductive Health
EmONC	Emergency obstetric and newborn care
ERS	Economic Recovery Strategy
FGM	Female genital mutilation
FGM/C	Female genital mutilation/cutting
FHOK	Family Health Options of Kenya
FIDA	Federation of Women Lawyers
GBV	Gender based violence
GDP	Gross domestic product
GIZ	Gesellschaft für Internationale Zusammenarbeit (German Technical Cooperation)
GNI	Gross national income
GOK	Government of Kenya
GRPHCS	Global Programme to Enhance Reproductive Health Commodity Security
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HRH	Human resources for health
ICPD	International Conference on Population and Development
ICRH	International Center for Reproductive Health
IRC	International Rescue Committee
KEMSA	Kenya Medical Supplies Agency
KES	Kenyan Shilling

KEWOPA	Kenya Women Parliamentary Association
KMTC	Kenya Medical Training College
KNBS	Kenya National Bureau of Statistics
KPHC	Kenya Population and Housing Census
KRC	Kenya Red Cross
KSPA	Kenya Service Provision Assessment
LMIS	Logistics management and information system
M&E	Monitoring and evaluation
MDG	Millennium Development Goal
MHTE	Maternal Health Thematic Evaluation
MHTF	Maternal Health Thematic Fund
MISP	Minimum initial service package
MMR	Maternal mortality rate
MoH	Ministry of Health
MoPHS	Ministry of Public Health and Sanitation
MOYAS	Ministry of Youth Affairs and Sports
MTP	Medium-term plan
MUMCOP	Mumia`s Muslim Community Programme
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NCAPD	National Coordinating Agency for Population and Development
NCCK	National Council of Churches of Kenya
NDP	National Development Plan
NHSSP	National Health Sector Strategic Plan
PCEA	Protestant Church of East Africa
PDR	People's Democratic Republic
PMTCT	Prevention of mother-to-child transmission
PRSP	Poverty Reduction Strategy Paper
RHCS	Reproductive Health Commodity Security
STI	Sexually transmitted infections
SWAp	Sector wide approach
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund

USAID	United States Agency for International Development
USD/US$	US-dollar
WHO	World Health Organization

1. Purpose and scope of the evaluation

Maternal health remains a major challenge to health systems worldwide. The world is on track to reach some targets of the Millennium Development Goals (MDGs) by 2015, but falling short on others; maternal health is the least likely to meet the 2015 target. A recent analysis found an annual rate of reduction of 1.3 percent during the period of 1990–2008, well short of the 5.5 percent needed to attain the MDG target by 2015. At the current rate of decline, it will take more than 188 years to meet the goal of 100 per 100,000 live births.

Given the current lack of sufficient progress in tackling maternal mortality, it is critical that effective interventions are implemented and monitored. Careful evaluation of these interventions is crucial for determining what works and for ensuring that scarce resources are allocated effectively. This is particularly true for developing countries, where maternal mortality is highest and access to maternal health services is poor. For this reason, United Nations Population Fund (UNFPA)has launched the evaluation of its support to maternal health in the last eleven years and the mid-term evaluation of the Maternal Health Thematic Fund. Following the terms of reference, the evaluation covers the period from 2000 until 2010, and also includes information related to a number of interventions implemented in 2011.

The aim of conducting both evaluations in parallel; i.e. the Maternal Health Thematic Evaluation (MHTE) and the Mid-Term Evaluation of the Maternal Health Thematic Fund (MHTF); is to take advantage of potential synergies in the evaluation portfolio of UNFPA and obtaining deeper and better substantiated insights on the thematic area of maternal and reproductive health as a whole, as well as on the MHTF individually.

1.1 Scope of the Maternal Health Thematic Evaluation

The MHTE assesses to what extent UNFPA support to maternal health has been relevant, effective, efficient and sustainable in contributing to the improvement of maternal health. The evaluation covers all programmatic interventions that have been directly relevant to maternal mortality and morbidity within UNFPA mandate, including all activities financed from core and non-core resources; and those financed through UNFPA Reproductive Health Thematic Funds.[1] MHTE focuses on key elements of reproductive health including family planning, skilled birth attendance and Emergency Obstetric and Newborn Care (EmONC), i.e. the "three pillars" of reducing maternal mortality. The specific thematic scope of the MHTE is defined by a list of twelve evaluation questions (a table with all evaluation questions and related judgment criteria is presented in Annex 6.3).

1. I.e., the Maternal Health Thematic Fund, the Global Programme to enhance Reproductive Health Commodity Security and the joint UNFPA-UNICEF FGM Programme.

1.2 Geographical scope of the overall evaluation

The scope of this evaluation is limited to those 55 countries whose maternal mortality ratio in the year 2000 was higher than 300 deaths per 100,000 live births. The main rationale for this delimitation of the scope is to allow the evaluation to a) include those countries that have or have not made improvements in addressing maternal heath since the year 2000; and b) to focus the analysis on those countries that, relative to others, have experienced the greatest challenges in improving maternal health in accordance with MDG5.

1.3 Purpose and structure of this country report

This country report has been prepared following the completion of the country case study in Kenya and summarizes its findings and conclusions. The findings presented in this country report, together with nine other case studies, inform the final evaluation report for the MHTE. [2]

The country report is structured as follows:

- Chapter 2 explains the case study methodology. It discusses:
    - The process and criteria for selecting case study countries overall, and the specific reasons for choosing Kenya as a case study
    - The preparation and conduct of the case study
    - The limitations and constraints experienced by the evaluation team
- Chapter 3 provides a short description of the reproductive health sector in Kenya, and describes the overall approach of UNFPA to supporting maternal health in the country.
- Chapter 4 presents the findings of the country case study.
- Chapter 5 presents the conclusions of the country case study drawing on the findings for each of the evaluation questions. While Chapter 5.1 draws conclusions for UNFPA overall maternal health support in the country, Chapter 5.2 focuses on the added value of the Maternal Health Thematic Fund.
- Chapter 6 presents the annexes of this country report including a list of all documents consulted and a list of people interviewed for this case study. The annexes also contain key data for Kenya, the methodological instruments utilized for this case study and a list of UNFPA interventions and activities in Kenya.

2. Final evaluation report is available on the following web page: http://www.unfpa.org/public/home/about/Evaluation/EBIER/TE/pid/10094.

2. Methodology of the case study

The methodology for the case study has been developed based on the overall methodology for the MHTE and the mid-term evaluation of the MHTF (see final reports). The purpose of the country case study is to use the field visit to collect data and information to verify the hypotheses developed during the desk phase of the evaluation and to further inform the answers to the evaluation questions.

2.1 The selection of country case studies

2.1.1 The process and criteria for selecting country case studies

The evaluators carried out a comprehensive staged sampling process to select the countries to be included in the field phase of the evaluation. The first sampling stage resulted in the selection of all 55 UNFPA programme countries with a maternal mortality ratio (MMR) higher than 300 deaths per 100,000 live births in the year 2000. In the second sampling stage, 22 countries out of the initial 55 were selected for inclusion in the extended desk phase. In order to ensure that different types of country contexts were included in the second-stage sample, the countries were grouped and selected according to the following criteria (see Table below).

Criteria used to create a typology of desk phase countries

Selection Criteria
Relative success of programme countries in improving maternal health (to include "high-performing" and "low-performing" countries);
Average income level in the different programme countries (to include countries with different poverty levels as one determinant of maternal health);
Quality of the public administration (to include countries with different administrative capacities to develop and manage maternal health programmes); and
Relative prevalence of HIV (to include programme countries whose maternal health situation was interlinked with a high incidence of HIV).

In the third sampling stage, ten countries out of the group of 22 were selected for in-depth case studies (field phase);[3] eight of these countries were recipients of the Maternal Health Thematic Fund (MHTF). Case studies were selected so that each type was represented by two cases: One country that had made large improvements; and a similar country (according to the above selection criteria) that only achieved small improvements in reducing maternal mortality. Overall, this systematic approach to selecting countries for the field phase allowed for different types of country contexts to be equally covered by the evaluation.

3. The sampling criterion has been selected to establish a close ling to the MDG5 indicators. The data have been taken from the H4 report "Trends in Maternal Mortality: 1990-2008" in agreement with UNFPA.

2.1.2 Justification for selecting Kenya

Within the sample of ten countries selected for the field phase, Kenya was one of four countries that had made little progress in reducing maternal mortality: the maternal mortality ratio (MMR) of 560 deaths per 100,000 live births decreased by only 30 deaths between 2000 and 2008,[4] representing a reduction of only 5.4 per cent in eight years. The performance of Kenya in this respect lagged behind most other countries whose MMR remained above the important threshold of 300 deaths per 100,000 live births.

Another context factor that was considered in selecting Kenya as a case study country was its relatively high per-capita gross national income (GNI) of US$1,628.[5] The assumption was that the higher resource availability would influence the ability of a government and of a society to address certain bottlenecks in maternal health service provision with its own resources. In turn, this circumstance would change the demands made on UNFPA to support the efforts to reduce maternal mortality. Kenya also scored highly in the category of 'quality of public administration. This was interpreted to mean that the Kenyan government would have a greater capacity than governments in other case study countries to address many of its own challenges with greater independence from development partners.

Lastly, Kenya has also been affected by a very high HIV prevalence. This was assumed to make the task of reducing maternal mortality more challenging for the government as well as for UNFPA, and to require an adaptation of the maternal health approach of UNFPA, in comparison with other countries without a high HIV incidence.

2.2 Scope of the country case study

This country case study is one of several evaluation components used to collect evidence to answer the global evaluation questions and judgment criteria[6] of the two evaluations.[7] As these evaluations draw on a number of different information sources, this country case study provides only some of the information that is required to answer the global evaluation questions comprehensively.[8] The scope of the country case study is defined by the "issues to assess", which are listed at the beginning of the findings-section for each evaluation question, together with the judgment criteria they correspond to.[9] These "issues to assess" were defined after analyzing the global maternal health strategy of UNFPA and its underlying theory of change. Based on this analysis, the evaluation team determined which parts of this theory of change were the most important for the overall success of UNFPA maternal health strategy. The global list of issues to assess was then adapted to the context of the case study country.[10] The country case study focuses on collecting information on these

4. Based on data from (WHO, UNICEF, UNFPA, World Bank, 2010).
5. This puts Kenya into a group of countries with per capita GNIs higher than US$1,000, along with Cambodia, Ghana, and Lao PDR as countries that have made relative progress in lowering their maternal mortality ratio; and Burkina Faso, Sudan and Zambia that, similar to Kenya itself, have not achieved a significant reduction of maternal mortality.
6. During the inception phase of this assignment, the focus of each of these global evaluation questions had been sharpened by defining a set of judgment criteria that specified which aspects of UNFPA associated support to maternal health should be at the center of attention for each evaluation question. These judgment criteria define in greater detail the specific conditions of success of UNFPA support in each of the thematic areas covered by the evaluation questions. For a more detailed explanation of judgment criteria, please see the final reports of the MHTE and MHTF evaluations.
7. I.e., the Maternal Health Thematic Evaluation; see Chapters 1.1.
8. Twelve evaluation questions for the Maternal Health Thematic Evaluation and eight evaluation questions for the MHTF mid-term evaluation.
9. A complete list of issues to asses for this country is also contained in Annex 6.3., the data collection results matrix for this country report.
10. Issues addressed may vary from one country case study to the other. Only issues which have been addressed in this specific country

specific issues and the findings presented in this country report do not provide complete answers to the global evaluation questions.[11] Recommendations are not elaborated at this stage, as the overall conclusions to the evaluation questions will only be developed at the level of the final reports for the MHTE/MHTF evaluations.

Since the 20 global evaluation questions of the two evaluations[12] are designed to assess the relevance, efficiency, effectiveness, and sustainability[13] of the support to maternal health provided by UNFPA, the issues to assess that were derived from the evaluation questions are also related to these four DAC standard evaluation criteria.

2.3 Preparation of the country case study

The evaluation team prepared this country visit in cooperation with the UNFPA country office. The evaluation team mapped the relevant stakeholders, selected interviewees, identified data sources and selected data collection approaches to ensure that information on each particular issue would be collected:

1. From different sources, such as from different stakeholders, to reflect potentially differing perspectives; or from different documents (data triangulation).
2. Using complementary data collection methods, i.e., a mix of quantitative and qualitative methods, such as the use of secondary data on maternal health from demographic health surveys; and the use of feedback from key informant interview and focus groups (methodological triangulation).[14]

An overview of the triangulation for each evaluation question is presented in Annex 6.2.

2.4 Data collection methods and analysis during the country case study Kenya

The evaluation team used the following approaches for collecting data during the country visit to Kenya:

- The evaluators conducted a series of individual interviews in Nairobi, i.e., with staff from UNFPA country office and with representatives of the main UNFPA partners in the country, including governmental, non-governmental, development, and other implementing partners. In these interviews, the team focused on the collection of qualitative data that would help to provide contextual information on UNFPA interventions, its contributions and roles in partnerships, etc.
- During the country visit, the team collected and reviewed additional documents that either had not been available during the desk phase; or that needed to be revisited to verify particular information that had been received during one of the interviews. Evaluators focused in particular on the following types of documents:

    - Annual work plans (AWPs), in particular those AWPs that had not been available to the evaluation team during the desk phase.

---

case study are shown in the tables in front of each evaluation question and in the Annex. This might lead in some occasions to difficulties in linking issues and judgment criteria but this is unavoidable as the methodology has been designed for the overall global evaluations.

11. See also the final reports of the MHTE and MHTF evaluations for more details on the methodological approach.
12. The Maternal Health Thematic Evaluation and the MHTF Mid-Term Evaluation.
13. Development Assistance Committee (DAC) evaluation criteria.
14. E.g., semi-structured interviews, focus groups, document reviews.

- Relevant national strategic documents including policies and strategic frameworks for sexual and reproductive health policies, maternal health policies, family planning, EmONC and other relevant topics.
- Needs assessments and other inputs into the policy-making process that UNFPA had supported or implemented, covering all relevant maternal health topics.
- Documents that described and defined the relationship of UNFPA with its partners in the country, such as Memoranda of Understanding (MoUs) with development partners or government.
- Evaluations or assessments of UNFPA maternal health support in the country that had not been available to the evaluation team during the desk phase of this evaluation.

- During the visit, the team traveled to the Western Region to visit a selection of intervention sites funded by UNFPA (please see the work plan in the Annexes for details). The team interviewed representatives from local authorities, staff of health centers that had received UNFPA support, and implementing partners. The team also conducted several focus group discussions with beneficiaries of UNFPA support, such as midwives, fistula survivors, and youth groups.

At the end of the visit to Kenya, the evaluation team did a preliminary analysis of their findings for each of the evaluation questions. These findings were presented to the UNFPA country office prior to the departure of the team. In addition, the team formulated conclusions on a number of topics that cut across the thematic areas covered by the evaluation questions. These conclusions constitute an assessment of selected aspects of UNFPA support to maternal health in Kenya. However, due to the selective nature of the case study, these conclusions do not necessarily form a comprehensive and complete assessment of UNFPA support of sexual and reproductive health in the country, as would have been the case in a country programme evaluation of Kenya. These conclusions are presented in Chapter 5. Details on the approach for comparing maternal health support financed by core funds and support from the MHTF can be found in the final reports for the MHTE and the MHTF evaluations.

2.5 Limitations and restrictions

During the country visit, the evaluators encountered the following challenges or constraints:

Table 1: Challenges or constraints encountered throughout the field phase and reactions

Challenges/constraints encountered	Reactions
Some key informants had assumed their positions only shortly before the visit of the evaluators. Their knowledge of the interventions and of the history of cooperation with UNFPA was therefore limited.	Evaluators used information from programme documents and from other interviews to complement the information.
Project officers from WHO and the World Bank were absent from Kenya during the country visit.	Evaluators obtained documents to provide information on UNFPA cooperation with WHO and the World Bank.
The distant location of the International Centre for reproductive health, Mombasa, made it impossible to visit the site and to conduct interviews.	Evaluators obtained information on the interventions from other sources (documents, interviews with other implementing partners and government partners).

3. Short description of the reproductive health sector

3.1 Country Background

From its independence from Britain in 1963 until the mid 1980s, Kenya was economically and politically stable. However, since the early 1990s, corruption, government inefficiency and political instability have increased. The government, which has been in power since 2003, has attempted to overcome the crisis by liberalizing the economy, fighting corruption and improving the rule of law. The presidential elections of 2007 ended in dispute, with both the government and the opposition claiming victory. Violent conflicts broke out among the population, particularly in the urban slums and in the west of the country, claiming a large number of lives and between 400,000 and 600,000 persons were displaced. A peace deal brokered by the United Nations (UN) was signed by the parties involved in the conflict in February 2008. Since then, Kenya has been governed by a grand coalition, which created two Ministries of Health (MoH and MOPHS). Their responsibilities partially overlap and thus constitute an additional burden to coordination of health programmes. Following a referendum and adoption of a new constitution in August 2010, Kenya is now divided into 47 counties that are semi-autonomous units of governance. These units are expected to be fully institutionalized by August 2012 in time for the first general election under the new constitution

Table 2: Key economic data for Kenya

Total Population Kenya (2009)	39,802,000
GDP (2009 million current US$)	29.4 billion
GDP/ per capita (2009 million current US$)	739

Source: UN Statistical Service UN Data.

3.2 Kenyan Health Sector

Health services in Kenya are provided by a wide range of actors. Health care providers include the government, faith-based organizations (FBOs), other non-profit organizations, for-profit service providers and traditional healers. About 40 per cent of the services are provided by the private sector. Public health services at the lower levels of care - where the poor and in particular poor women mainly seek their care – are particularly weak. The reasons for this situation are diverse, namely: (i) funds are not disbursed to health facilities in a timely manner, which hampers the provision of adequate operational and maintenance activities; (ii) there is a shortage of health staff in rural areas, due to a lack of incentives for staff to work in those locations, and inefficient deployment and management of staff; (iii) there is considerable waste and leakage, as well as insufficient supplies, of drugs and medical supplies; and (iv) planning and management capacities are still weak, despite some improvements in recent years. Many remote areas rely on FBOs for basic care.

The Ministry of Health sets policies, develops standards, and allocates resources for health care services; however, in accordance with the decentralization process, the district is the level at which most management of services takes place. The ongoing process of devolution will create a new health service delivery environment with changed roles and responsibilities. The two ministries responsible for health since 2008 are due to be reunited within the next few years. The National Health Sector Strategic Plans (NHSSPs) were followed in 2007 by the National Reproductive Health Policy 2007-2011, which is the first reproductive health policy for Kenya.

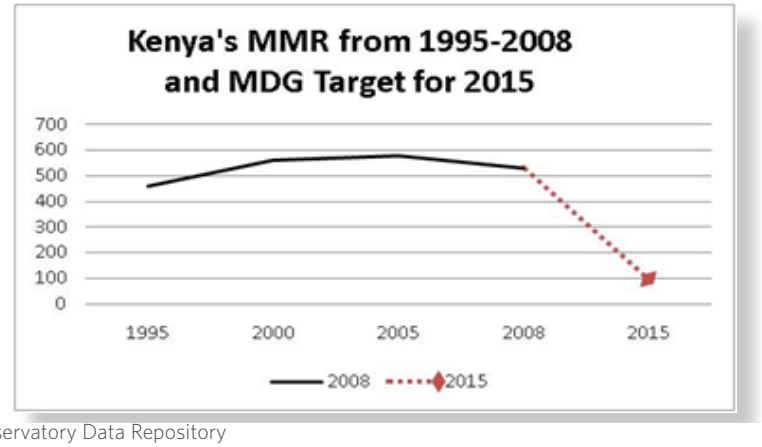
The framework for health policies in the country was set by the Poverty Reduction Strategy Papers (PRSP) issued in 2001 and 2003 (Economic Recovery Strategy (ERS). The ERS was the strategic plan of Kenya for recovering lost ground in development and addressing poverty. The PRSPs were accompanied by the 9th National Development Plan (NDP) from 2002-2008. The 9th NDP addressed the medium term poverty reduction challenges. It consolidated and harmonized into a single framework all the welfare perspectives of development including provision of social services, maintenance of political stability and economic development.

Kenya Vision 2030 is the new national development strategy covering the period 2008 to 2030. It is based on three "pillars": namely; the economic pillar, the social pillar and the political pillar. It is to be implemented in successive five-year medium-term plans and is a broad policy statement for the long-term. Population dynamics, reproductive health, HIV/AIDS, youth and gender equality are comprehensively incorporated in the first medium-term plan (MTP, 2008-2012), which is the medium-term plan of the country for accelerated achievement of the Millennium Development Goals (MDGs). A handbook of national reporting indicators for the Vision 2030 first medium-term plan was developed in 2009 and includes indicators on population dynamics, including marginalized groups, reproductive health, HIV/AIDS, and maternal health and gender equality.

3.3 Health Indicators

The continued high growth rate of the population in Kenya (38.6 million in 2009) has contributed to a youthful population with over 40 per cent under the age of 15 years.

Figure 1: Maternal Mortality Ratio Kenya, 1995-2008 and 2015 MDG 5 target



Source: WHO Global Health Observatory Data Repository

Between 1989 and 2009, the total fertility rate declined from 6.7 to 4.6 children per woman. Even if the fertility rate declined to 3.7 in 2030, the population would still reach 65.9 million. Maternal mortality remains high with the maternal mortality ratio (MMR) officially estimated to be approximately 488 per 100,000 live births (unofficial estimates are MMR of approximately 1,000).[15]

However, while the contraceptive prevalence rate increased from 39 per cent in 2003 to 46 per cent in 2007, it is still far below the MDG target of 70 per cent. The unmet need for family planning is estimated at 25.6 per cent in 2009. The proportion of women who deliver with skilled birth attendants is only 44 per cent and has remained largely unchanged since 1993. The number of women aged 15-49 who have experienced female genital mutilation/cutting remains high at 27.1 per cent. The incidence of obstetric fistula is estimated at 3000 women annually, with factors such as poverty and the associated stigma making most women living with fistula invisible to policy makers. Neonatal mortality is a particular concern and little progress has been made: 6 out of 10 infant deaths occur during the first 28 days of life. The HIV/AIDS prevalence rate is currently 6.3 per cent, women constituting nearly two thirds of the infected.[16]

Kenya is on track to achieve some of the MDGs. With improved gender parity in education, Kenya may also achieve one of the targets of MDG three. However, it is unlikely that Kenya will eradicate extreme poverty and hunger (MDG 1), as per-capita gross national income growth rates have been too low and erratic to reduce sharply the proportion of people living in poverty. Also, although the preliminary results of the 2008/09 Demographic and Health Survey (DHS) indicate significant improvements in child health, Kenya is still unlikely to achieve MDG four. Malnutrition remains a key contributor to child and infant deaths in Kenya. Maternal mortality did not improve significantly in the 2000s, and MDG five also remains out of reach.[17]

15. DHS 2008/09.
16. DHS 2008/09.
17. According to the DHS 2008/2009 "the data on the survival of respondents' sisters were used to calculate a maternal mortality ratio for the 10-year period before the survey, which was estimated as 488 maternal deaths per 100,000 live births. This is statistically insignificantly different from the rate of 414 maternal deaths per 100,000 live births for the ten-year period prior to the 2003 Kenyan

Table 3 presents data for key maternal health indicators from the most recent Demographic Health Survey for Kenya (2008/09):

Table 3: Maternal Health Indicators. Kenya Demographic Health Survey 2008-2009

Maternal Mortality Ratio	488
MDG target for Maternal Mortality Rate[18]	95
% HIV Prevalence Rates (aged 15-49)	6.3
% Current Use of Contraception (All methods)	45.5
% Antenatal Care Coverage, at least one visit	91.7
% Antenatal Care Coverage, at least four visits	-
% of Births attended by health personnel	48.5
% Unmet Need for family planning (Total)	25.6

Source: Kenya Demographic and Health Survey (DHS) 2008-2009

DHS. Thus, it is impossible to say with confidence that maternal mortality has changed".

18. UNDATA.

3.4 UNFPA response to maternal health in the country

Geographic coverage of UNFPA support	Support at national, district and community level
	Intensive support in three (previously nine project sites)
Population covered by UNFPA support	41,070,934 (all regions)
% of population in Kenya covered by UNFPA support	100%
Total spending regular sources 2004-2010 (ATLAS)	US$ 6.396.404,42
Total spending regular sources per capita	US$ 0,15 (all regions)
Total spending other sources 2004-2010 (ATLAS)	US$ 601.721,55
Total spending other sources per capita	US$ 0,01 (all regions)
Allocation according to CPAP 2004-2008 (6th country programme)	Total: US$ 12.000.000 out of which: 9.500.000US$ regular sources 2.500.000 US$ other sources Reproductive Health Component: 6.000.000US$ Population and Development Component: 4.550.000US$ Coordination and Assistance: 1.450.000 US$

Source: Calculation by evaluation team based on UNFPA sources

The current 7th country programme action plan (CPAP) 2009 -2013 is aligned to the Kenya Vision 2030 (the national development strategy), to the United Nations Development Assistance Framework (UNDAF) and the UNFPA Strategic Plan 2008-2011. With regard to reproductive health, the CPAP pledges to help establish universal access to reproductive health and comprehensive HIV/AIDS prevention by 2015 and 2010, respectively.

As with the previous country programme action plans, the most recent programme focused on strengthening the institutional and technical capacity of implementing partners to provide a range of reproductive health and HIV/AIDS prevention services. This includes a referral system for emergency obstetric and newborn care (EmONC) (by creating four centers of excellence, reproductive health commodity security, without supporting purchases of commodities), and capacity development for service providers and youth in behavior change communication.

UNFPA has supported reproductive health at national, district and community level. While the 6th CPAP amounted to an overall funding of US$12 million for five years, the 7th CPAP allows funding of US$5.1 million per year. This funding amount has allowed intensive support to four project sites (reduced from previously nine districts in the 5th CPAP to four districts in the 6th CPAP) and to nationwide programmes on HIV/AIDS, youth and gender). The UNFPA capacity has not allowed the roll out of assistance to other regions beyond those currently served.

The decision to reduce UNFPA project sites had been taken jointly with the Division of Reproductive Health at the national Ministry of Health. The Ministry plans to create centers of excellence for reproductive health in remote areas to serve hard to reach populations and proposed to UNFPA to pilot these centers in four districts. UNFPA is to cover all aspects - from construction and/or renovation of buildings to equipping and training of staff, as well as supporting referral services

4. Findings of the country case study related to MHTE

The following section presents the findings of the country case study.

4.1 Findings related to the MHTE

4.1.1 Evaluation question 1: Relevance/Coherence

Evaluation question 1

To what extent is UNFPA maternal health support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?

Judgment criteria[19]	Issues to address (field phase)
1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/ vulnerable groups	To what extent do UNFPA/implementing partner monitoring tools include indicators to capture the specific situation of the most vulnerable?
1.3. Needs orientation of planning and design of UNFPA supported interventions	To what extent have UNFPA country offices (COs) utilized information from needs assessments other than the Common Country Assessments (CCAs)?
	To what extent are country offices using means alternative to UNDAF process for needs-oriented planning and the identification of the most vulnerable groups?

Judgment criterion 1.2

- (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/ vulnerable groups

Since the 4th country programme the UNFPA country office has supported the availability of accurate and sufficiently disaggregated data for planning, implementation and evaluation of population and reproductive health programmes. The Demographic and Health Survey (DHS) and census identify specific vulnerable groups and include data on HIV/ AIDS, sexually transmittable infections (STI) and maternal mortality. The number of users of data could not be ascertained.[20] However, the considerable amount of resources that donors and government partners have invested into these surveys indicates the importance of the data for the development community in Kenya.

19. For indicators associated with the judgment criteria, please see the final reports of the MHTE and MHTF evaluations.
20. Country Programme Performance Summary, June 2008.

UNFPA has supported demographic health and household surveys in Kenya since 1999, using resources from the population and development programme component. These surveys collect data on maternal mortality, antenatal visits, delivery in health facility, the prevalence of modern contraceptive methods and health seeking behavior in addition to socio-economic data. The DHS 2008/2009[21] disaggregated demographic, socioeconomic and health data for rural and urban populations down to the level of provinces. UNFPA ensured the inclusion of an HIV module in the DHS 2008/2009 and the collection of data on persons with disabilities and the elderly. UNFPA country office also provided technical and financial support for the Kenya AIDS indicator survey.

National and international strategies and programmes such as the UNFPA country programmes, the United National Development Action Framework (UNDAF), the Millennium Development Goals (MDGs) and the Medium-Term Plan (MTP1) of the Kenya Vision 2030 aim at improving maternal health in Kenya and address a broad range of vulnerable population groups (such as women, girls, youth, extremely poor, disabled and elderly, remote, hard to reach populations).[22] The reproductive health sub-programme of the 5th country programme (CP) (1997 to 2001)[23] had addressed 'pastoralist communities, slum dwellers, youth and adolescents, widows and orphans' as target groups. UNFPA has targeted vulnerable populations primarily geographically, based on the assumption that there were more vulnerable populations in remote, rural, and hard to reach areas.

Judgment criterion 1.3

- Needs orientation of planning and design of UNFPA supported interventions

Needs-oriented planning has been based on nationwide general or targeted surveys as well as on community level assessments, supported by UNFPA and other partners. Priorities for interventions and geographical locations have been set by the governmental partners. In spite of the fact that vulnerable populations exist country-wide, the country office has focused its support on four pilot sites, the 'centers of excellence'. Intensive monitoring and evaluation was meant to provide evidence for the eventual expansion of such centers nationwide.

UNFPA has technically and financially supported the design of surveys, needs assessments and interventions in close coordination with relevant line ministries, agencies and other development partners. The National Coordinating Agency for Population and Development (NCAPD) has been the main link between the UNFPA country office and the Kenyan Government. The NCAPD has been coordinating all stakeholders, including all implementing partners of UNFPA in reproductive health.

UNFPA has supported a range of needs assessments/surveys related to maternal health, including the baseline assessment of obstetric fistula in 2004, a situation analysis on female genital mutilation and cutting (FGM/C) in 2007 and a study on the added value of midwives in 2008. The country office also conducted several rapid needs assessments during the post-election violence period in 2008.

Priorities for programming were set predominantly by governmental partners, consistent with the UNFPA mandate. The country office was responsible for implementation of discrete projects spread over nine districts, on a wide range of topics (adolescent pregnancy, female genital mutilation, unsafe abortion, legal and reproductive rights, drug abuse, poverty, food security for widows and orphans, integrated reproductive health services, sexually transmittable infections), but lacked provisions for synergy and linkages between projects. This led to the fragmentation of UNFPA assistance and limited the potential for significant contributions of the support to improved maternal health outcomes.[24] Consequently, the decision was taken, led by the Ministry of Health (MoH), to focus the UNFPA support on four centers of excellence and to enable the country office to provide a comprehensive range of services at these four sites

21. Kenya DHS 2009 Final report, http://www.measuredhs.com/pubs/pdf/FR229/FR229.pdf, accessed 20th Feb 2012.
22. i.e. UNDAF 2009-2013, CPAP 2004-2008.
23. Final evaluation report on the UNFPA 5th country programme of Assistance to the Government of Kenya (1997-2001).
24. Final evaluation report on the 5th UNFPA country programme; and final report of the mid-term review of the 6th UNFPA country programme.

4.1.2 Evaluation question 2: Harmonization and coordination of maternal health support and partnerships

Evaluation question 2

To what extent has UNFPA successfully contributed to the harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?

Judgment criteria	Issues to address
2.1. Harmonization in maternal health partnerships between UNFPA and United Nations (UN) organizations and World Bank (including H4+)[25] at global; regional and country level	To what extent do functioning mechanisms for coordination and harmonization of planning and implementation in United Nations joint programmes exist? What is the extent of use of pooled funding in United Nations joint programmes?
	What is the significance of H4+ country teams for country level maternal health harmonization and coordination?
2.2. Harmonization of maternal health support through partnerships at country and South-South/regional level	Does the donor community consider the national maternal health road maps to be viable components of a national health policy that allows them to use it as a focal point for aligning their support with government structures and mechanisms?
	Is UNFPA financing activities that are geared at facilitating the adoption and implementation of maternal health road maps, i.e. activities that identify and address existing bottlenecks in maternal health road map operationalization and implementation at country level?
2.3. UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda	What kind of evidence related deliverables that were meant for adaptation at country level have been produced by partnerships for evidence creation?

Judgment criterion 2.1

- Harmonization in maternal health partnerships between UNFPA and UN organizations and World Bank (including H4+) at global, regional and country level

The harmonization of maternal health partnerships is promoted by donors and the Government of Kenya (GoK). The UNFPA country office has been participating in the H4+ initiative and the relevant donor coordination mechanisms and has implemented some joint programmes with other UN organizations. However, UNFPA has not taken the lead in launching coordination mechanisms, joint programmes or working groups.

Donor contributions have been strongly regulated by the government at national and district level. All high-level coordination mechanisms have been chaired by representatives of the respective line ministries. Specific sub-working groups have been

25. UNFPA, UNICEF, World Bank, World Health Organization (WHO), UNAIDS.

chaired on a rotational basis. Annual work plans and their monitoring and evaluation (M&E) components have been developed by all partners in line with the relevant government strategies. Monitoring has been done jointly at all levels and on a regular basis (quarterly and annually).[26] In theory, a sector-wide approach is in place in Kenya's health sector, but no corresponding joint funding mechanism exists. However, the World Bank, the Danish International Development Agency (DANIDA) and the Government have pooled their funds for commodity purchases.

The UNFPA country office has been participating in three joint UN programmes on female genital mutilation and cutting (FGM/C) (UNFPA has contributed 50 per cent of the budget to the FGM/C joint programme), gender and HIV/AIDS. In the FGM/C joint programme, UNFPA and UNICEF operate in different geographic areas to make optimal use of funds.[27] The joint HIV/AIDS programme (UNFPA, UNICEF) was put in place to comply with a requirement from the Department for International Development (DFID) for joint programming and implementation as a precondition for funding. The implementation is regarded as successful.[28]

The UNFPA country office has been absent from a number of important coordination and technical meetings in reproductive health.[29] In January 2011, for example, DFID launched a working group on the 'reproductive health programme business plan design', with the participation of local and international partners (Department of Reproductive Health of Ministry of Health, German financial cooperation (KfW), German technical cooperation (GIZ), DANIDA, United States Agency for International Development (USAID), and UNICEF). However, UNFPA has not been a member of this working group.

Judgment criterion 2.2

- Harmonization of maternal health support through partnerships at country and South-South/regional

The UNFPA country office supported the development of a maternal newborn health road map and other national strategies and policies relevant for maternal health. However, the translation of these policies and strategies into operational plans had not yet been sufficiently addressed at the time of this evaluation, neither by the Kenyan Government and development partners, nor by UNFPA itself.

The UNFPA country office supported the development of the first National Reproductive Health Strategy in 1996 and the reproductive health policy of 2007, which incorporates the Maputo Plan of Action. However, the national maternal health road map, which had been developed by the Kenyan Government to translate the principles of the Maputo Plan of Action into a national strategy, was put on hold in 2011. It was replaced by the "Government High Impact Initiative" which has a main focus on family planning, emergency obstetric care, insecticide treated bed nets and vaccination.

According to the Ministry of Health, policy development in Kenya allows external partners only as 'silent observers' to the policy-making discussions. Nevertheless, the UNFPA country office has been instrumental in advocating for legal reforms on female genital mutilation and cutting (FGM/C) in cooperation with the Federation of Women Lawyers (FIDA), Kenya Women Parliamentarians Association (KEWOPA), and the Ministries of Health and Education. Based on these efforts, the national act against FGM/C has been passed into law in October 2011. UNFPA also advocated for increased investments in maternal health among Kenyan parliamentarians. This initiative led the Kenyan Government to make funds available dedicated to reproductive health programming for the first time (during the 5th UNFPA country programme).

26. Information from implementing and development partners.
27. Information from development and government partners.
28. Information from interviews with UNFPA, UNICEF.
29. Information from development partners, government partners. The Kenyan UNFPA country office insists that they do attend and that they have been actively participating.

According to development partners, a large number of strategy and policy documents exist, often with overlapping scopes. However, at the time of this evaluation, these strategies had not yet been translated into concrete operational plans with associated financial flows.

Judgment criterion 2.3

- UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda

---

The UNFPA country office is partnering with development partners, research agencies and international non-governmental organizations to provide evidence for policy and strategy development.[30] In spite of having the power to convene a range of different partners to support maternal health, UNFPA had not yet fully utilized this capacity at the time of this evaluation.

UNFPA supported the Kenyan Demographic and Health Survey (DHS) in 2003 and 2009 and took the initiative to gather support from UNICEF, USAID and other donors to support the most recent DHS. Data from the recent DHS showed low uptake of family planning services and poor maternal health outcomes. This led the Kenyan Government to increase its focus on these issues. Both the Strategy for improving the Uptake of Long-acting and Permanent Methods of Contraception (2008) and the Reproductive Health Strategy 2009-2013 are based on data from the DHS.

The UNFPA country office has been a participant and co-chair of a variety of maternal health technical working groups and forums. The presence of UNFPA in these meetings has often been instrumental for bringing partners and government together.[31] However, limited staff numbers compared to other development partners has constrained the effective participation of UNFPA in all of the relevant technical working groups.[32]

30. See also evaluation question 1.
31. Interviews with development and governmental partners.
32. Information from development and governmental partners.

4.1.3 Evaluation question 3: Community involvement/demand orientation and civil society organization partnerships

Evaluation question 3

To what extent has UNFPA support contributed to a stronger involvement of communities that has helped increase current levels of demand and utilization of services, in particular through its partnerships with civil society?

Judgment criteria	Issues to address
3.1. Governments commitment to involve communities translated in sexual and reproductive health and maternal health strategies through UNFPA support	Examples of UNFPA support to create clear legal frameworks, regulations and guidelines to facilitate government partnerships with communities and civil society organizations
3.2. Civil society organization involvement in sensitization on maternal health issues and facilitating community based initiatives to address these issues supported by UNFPA	Examples of UNFPA support to civil society and communities to overcome the lack of financial support to civil society
	Examples of UNFPA coordination among implementing partnerships to bring together Governments and civil society organizations at local level to generate social capital through community participation.
	Examples of UNFPA-Government-civil society organization Joint Action and Monitoring Frameworks as mentioned by CPAPs.

Judgment criterion 3.1

- Governments commitment to involve communities translated in sexual and reproductive health and maternal health strategies through UNFPA support

UNFPA has supported the community-based approach of the Government of Kenya. Together with its implementing partners (such as the Ministry of Youth Affairs and Ministry of Gender), the UNFPA country office has initiated dialogues with women, youth and children to sensitize communities on reproductive health issues, including gender-based violence. Some positive results can be linked to UNFPA interventions. However, the lack of baseline studies has made it difficult to concretely link UNFPA support to changes in attitudes at community level.

The Government of Kenya has been committed to community participation, especially with respect to gender and youth. The mobilization of significant community members, such as elders, has been a key strategy for behavior change, and backed by political leaders and development partners. UNFPA helped to draft parts of the National Youth Policy and supported the creation of a National Youth Council, although the latter was not yet functional at the time of this evaluation. The UNFPA country office also supported the development of a dialogue tool for engaging policy makers and the development of youth empowerment centers. At the time of this evaluation, the Ministry of Health was in the process of integrating obstetric fistula management services and safe motherhood initiatives at selected sites, with UNFPA support.

In 2008, the issue of male involvement in reproductive health was picked up as priority area by the Ministry of Health. UNFPA helped the Government to mobilize male elders to speak out against the practice of FGM/C and gender-based

violence (GBV).[33] These activities also helped to raise awareness on the issues of gender and obstetric fistula.[34] UNFPA was strongly involved in these initiatives in its focal regions. In response to the need for increasing access to skilled assistance during birth, the country office supported the community midwifery programme and the creation of "Centers of Excellence" for reproductive health.

The UNFPA country office has been supporting community participation since its first country programme. However, in the absence of baseline studies in the respective communities (with appropriate audience segmentation), it has not been possible to demonstrate whether those interventions have helped to strengthen Kenya's maternal health policy framework.

Judgment criterion 3.2

- Civil society organization involvement in sensitization on maternal health issues and facilitating community-based initiatives to address these issues supported by UNFPA

UNFPA support helped to intensify community participation in efforts to integrate reproductive health services with measures to reduce the prevalence of harmful traditional practices. Community midwives were trained in order to increase access to skilled care in previously neglected areas of sexual and reproductive health, such as obstetric fistula, gender-based violence (GBV), adolescent and youth reproductive health and cervical cancer. Implementing partners have also received some training and are included in the review meetings and monitoring and evaluation missions together with counterparts from the district health administration.

UNFPA has supported community-based interventions mainly in cooperation with national non-governmental organizations and community-based health workers. These implementing partners were trained in results-based monitoring and accountancy, participated in study tours,[35] and received support to strengthen their local networks.[36] UNFPA has funded a number of trainings, including family planning, gender-based violence and fistula. Trainings were typically conducted by staff of the Ministry of Health, the Ministry of Public Health and Sanitation or the Ministry of Gender.

Annual work plans (AWP) are monitored jointly by the UNFPA country office, the Ministry of Public Health and Sanitation and the National Coordinating Agency for Population and Development (NCAPD). Joint planning meetings for the AWP and monitoring and evaluation missions coordinated by UNFPA have brought together civil society organizations and the Kenyan Government. The monitoring and evaluation officer of the UNFPA country office recently created a 'Programme Recommendation Tracking Tool', which helped to compile all recommendations made during the joint monitoring and evaluation missions to ensure adequate follow up, adjustment and improvements.

33. In Baringo, Meru, Pokot, and Kuria.
34. Interviews with community members.
35. Catholic Diocese of Naivasha and MUMCOP programme coordinators to Sierra Leone.
36. Christian leaders network under NCCK, gender-based violence networks, female genital mutilation (FGM) networks.

4.1.4 Evaluation question 4: Capacity Development - human resources for health

Evaluation question 4

To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal health?

Judgment criteria	Issues to address
4.1. Development/strengthening of national human resources for health policies, plans and frameworks (with UNFPA support)	What mechanisms had UNFPA applied to ensure that policy makers include reproductive health in national human resource plans; and to what effect?
	To what extent was UNFPA involved in country needs assessments to inform policy makers for human resources for health planning?
4.2. Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and emergency obstetric and newborn care to respond to sexual and reproductive health/maternal health needs	To what extent was UNFPA involved in supporting capacity development in management skills of policy makers and health administrative staff?
	Which mechanisms did UNFPA utilize to ensure applicability and usability of training; and to what effect?

Judgment criterion 4.1

- Development/strengthening of national human resources for health policies, plans and frameworks (with UNFPA support)

Support for the development of national policies for human resources for health was not part of either the 5th or the 6th UNFPA country programme. Due to a respective situation analysis of the available capacities in Kenya, UNFPA supported the inclusion of human resources for health indicators in surveys and assessments that subsequently were utilized by the government for planning and included in the indicator frameworks.

The Kenyan Government considered the human resource situation at technical and managerial level in the reproductive health sector to be adequate, and did not make significant demands for additional technical support. Sufficient number of specialists had been trained in Kenyan over the years to help fulfill Kenya's own needs, and even to provide international technical assistance to other countries.[37] Similarly, policy development capacity had been available within the country, which had reduced the need for external support in this regard. Nevertheless, the UNFPA country office and a number of other partners were included in policy dialogue and played a supporting role in the development of health strategies and policies (see evaluation questions one and two).

Surveys and assessments (Reproductive Health Needs Assessment (2001), Obstetric Fistula (2007), Service Provision (2009), Kenyan Demographic Health Survey (2009)) supported by UNFPA included indicators for human resources for health. Data and information from these surveys were used in government planning,[38] in the development of UNFPA country programmes, and for the adjustment of annual work plans. As part of the 7th UNFPA country programme (2009 – 2013),

37. Information from UNFPA country office and Government partners.
38. National Human Resources for Health Strategic Plan for 2009-2012.

UNFPA supported the revision of the national training manuals and training guides for obstetric fistula and midwifery. This was meant to ensure that training conducted by different organizations met common minimum standards and facilitated the scale-up of community midwifery programmes.

Judgment criterion 4.2

- Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual and reproductive health/maternal health needs

---

UNFPA has financially and technically supported skills training for health extension workers and midwives. The UNFPA country office complemented this assistance with the renovation and equipping of 'Centers of Excellence' in the four UNFPA focus regions which allowed trained health service providers to apply their newly acquired skills.

UNFPA has financed communication skills training for community health extension workers and 'ambassadors' for fistula repair, and has supported additional training for midwives. For example, over one hundred community midwives were trained in 2010. Implementing partners have followed up on the trainings with supervisory visits and review meetings; however, UNFPA has only occasionally participated in these visits. The trainings helped to increase the quality of services offered at community level. Review meetings between project nurses and community midwives have been used to identify challenges and areas where additional capacity development was needed.[39]

In addition, the UNFPA country office has supported the renovation, refurbishment and equipping of the "Centers of Excellence" in the four UNFPA focus regions to allow newly trained staff to directly apply their skills.[40] At the time of this evaluation, the UNFPA country office was planning to develop operational guidelines for the Centers of Excellence, based on experiences made since their launch. However, UNFPA had not yet developed a comprehensive and standardized monitoring and evaluation system to collect the required data.

---

39. See also evaluation question seven.
40. Renovation and refurbishment of the theatre in Kakamega Provincial General Hospital was funded by UNFPA to ensure that trained service providers could practice their skills.

4.1.5 Evaluation question 5: Maternal health in humanitarian contexts (relief, emergency/crisis, post-emergency/-crisis)

Evaluation question 5

To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?

Judgment criteria	Issues to address
5.1. Inclusion of sexual and reproductive health in emergency preparedness, response and recovery plans	To what extent is UNFPA involved in monitoring the effective application of joint response activities and utilization of its tools?
	Does the health cluster response plan include sexual and reproductive health based on UNFPA interventions?
5.2. Accessibility of quality emergency obstetric and newborn care, family planning and reproductive health/ HIV services in emergency and conflict situations	To what extent do UNFPA mechanisms/procedures facilitate timely/flexible response to maternal health needs in humanitarian situations?
	What is the comparative advantage of UNFPA maternal health support in post-emergency/humanitarian situations?

Judgment criterion 5.1

- Inclusion of sexual and reproductive health in emergency preparedness, response and recovery plans

UNFPA intensified its involvement in humanitarian assistance in 2008, in response to the post-election violence that took place that year. A newly assigned humanitarian focal point began to support mainstreaming of humanitarian issues, gender, gender-based violence and emergency response at all levels of service provision. Despite the recognition of its response to humanitarian needs in 2008, the UNFPA country office has encountered challenges to access funds under the Consolidated Appeals Process (CAP) and to ensure its visibility in this joint mechanism.

Prior to the 2007 Kenyan national election, UNFPA only had engaged in disaster response in Kenya in an ad-hoc manner. However, the humanitarian crisis brought about by the post-election violence in 2008 promoted the UNFPA country office to address humanitarian issues more comprehensively. As an immediate response to the humanitarian needs in 2008, UNFPA provided family planning commodities and emergency kits to the affected population, individuals and clinics. Both the national Government and affected provincial health administrations commended UNFPA for its quick response during that period.[41]

Since then, UNFPA has become a member of the reproductive health sub-cluster (part of the health cluster) led by the World Health Organization, and the gender-based violence sub-cluster (part of the protection cluster), led by United Nations High Commissioner for Refugees (UNHCR). The UNFPA country office has been facilitating the acquisition and distribution of supplies (e.g. Minimum Initial Service Packages (MISP)) through the Government and other implementing partners and has supported training of service providers on MISP.

41. Interviews with Government partners at national and provincial level.

UNFPA hired a staff member in 2008 who was named the staff focal point for humanitarian issues and emergency preparedness (i.e. UNFPA participation in the Consolidated Appeal Process). Since then, the focal point has been coordinating the humanitarian response of the UNFPA country office, and has been monitoring the implementation of any measures. This new position also enabled the UNFPA country office to intensify its cooperation on humanitarian issues with organizations such as GIZ, Save the Children, IRC and UNHCR. As a result, the UNFPA country office staff reported that they felt better prepared to react to crises.

Nonetheless, the UNFPA country office missed opportunities for funding and visibility in humanitarian assistance. None of the four proposals the UNFPA country office had prepared for the Consolidated Appeal Process (CAP) of 2011 were accepted for funding, reportedly due to procedural issues.[42] Also, the CAP 2011 did not mention UNFPA as a supporter of the DHS 2008/2009 in the section on completed needs assessments.[43]

Judgment criterion 5.2

- Accessibility of quality emergency obstetric and newborn care, family planning and reproductive health/HIV services in emergency and conflict situations

Since 2008, UNFPA has supported the availability of the Minimum Initial Service Package (MISP) and other commodities. The UNFPA country office also participated in joint humanitarian assessments that served as a basis to plan subsequent humanitarian support. At the time of this evaluation, UNFPA was considering intensifying its engagement in humanitarian issues in Kenya.

In response to the post-election crisis of 2008, UNFPA supported a six-month project (with a budget of US$3,238,890) to support the immediate health needs of approximately 500,000 internally displaced persons in 42 designated camps. The services included all elements of the Minimum Initial Service Package (MISP), as well as basic surgical and medical care, family planning and management of pregnancies, post-exposure prophylaxis, HIV prevention and management, treatment and psycho-social support for sexual transmitted infections. The UNFPA country office also collaborated with other UN agencies to assess humanitarian needs. These assessments provided a good baseline for subsequent interventions. The main implementing partner of UNFPA for humanitarian assistance has been the Kenyan Red Cross (KRC).

The ongoing refugee problem reinforced the commitment of UNFPA to maintain its involvement in humanitarian assistance. At the time of this evaluation, the humanitarian focal point of the UNFPA country office had promoted plans to establish a health facility in Daadab camp to provide sexual reproductive health services. These types of services had not appeared prominently in responses to emergency situations as responding organizations tended to focus on providing food and shelter.[44]

42. At the time of this evaluation, four proposals were in preparation for the CAP 2012.
43. Mid-term review CAP Kenya 2011.
44. Thematic Evaluation of UNFPA Humanitarian Response 2010.

4.1.6 Evaluation question 6: Sexual and reproductive health services – family planning

Evaluation question 6

To what extent has UNFPA contributed to the scaling up and increased utilization of and demand for family planning?

Judgment criteria	Issues to assess
6.1. Increased capacity within health system for provision of quality family planning services in UNFPA programme countries	Are national reproductive health strategies geared towards integration of family planning services in all service delivery points?
	Are the capacity development interventions designed strategically, taking into account national strategies and orientations, supervisory mechanisms, potential for replication?
	What are the mechanisms developed to ensure that training curricula and standards are adopted across the entire country?
6.2. Increased demand for and utilization of family planning services in UNFPA programme countries, particularly among vulnerable groups[45]	How has UNFPA supported community-based distribution of family planning commodities translated into sustainable national strategies?
	Are UNFPA supported initiatives contributing to the increase of family planning utilization among vulnerable groups?
6.3. Improved access to contraceptives (commodity security)	What are the mechanisms in place to monitor and follow up the Ministry of Health/responsible line ministry supply chain?
	What are the mechanisms in place to sustain actual achievements and government commitment to reproductive health commodity security?

Judgment criterion 6.1

- Increased capacity within health system for provision of quality family planning services in UNFPA programme countries

The UNFPA country office contributed to increased capacity for the provision of quality family planning services within the Kenyan health system. UNFPA has technically and financially supported the strengthening of the reproductive health commodity security system in Kenya to help ensure a regular and country-wide supply of reproductive health commodities. The UNFPA country office also has supported the implementation of the national policy to provide integrated family planning services.

45. Approximation of "increased demand", which is difficult to capture.

One of the main interventions of UNFPA in the years prior to this evaluation had been the strengthening of the reproductive health commodity security (RHCS) system through the establishment of the Commodity Management Unit at the Division of Reproductive Health in the Ministry of Public Health and Sanitation (MoPHS). This unit was able to facilitate a partnership between the MoPHS and UNFPA, USAID and KfW[46] to procure family planning commodities during the 6th UNFPA country programme. The national government contributed approximately 50 per cent, UNFPA 25-30 per cent, USAID 10-20 per cent and KfW 10 per cent of the funds. UNFPA advocacy with parliamentarians, senior government officials and the media helped to increase funding allocations to budget lines for reproductive health commodities.[47] The UNFPA country office also helped to strengthen the capacity of Kenyan Medical Supplies Agency (KEMSA), the national agency responsible for commodity procurement and dissemination, to forecast, finance, procure and distribute quality reproductive health commodities such as contraceptives, maternal health drugs and HIV commodities. In addition, UNFPA supported the development of the National Contraceptive Security Strategic Plan 2007-2012, which is a mechanism towards sustainable budgeting. In 2011 the national government financed the purchasing of 80 per cent of the required family planning commodities.

The integration of all services, including family planning, is a national policy. Implementation was ongoing at the time of this evaluation and was overseen by various technical working groups in which the UNFPA country office participated. Capacity development interventions were supported by UNFPA and conducted within the government framework according to standardized training curricula, which had been developed and were used country-wide by the Kenya Medical Training College (KMTC).[48] Upgrading of supportive supervision of skills was conducted by the district public health nurses. The capacity development interventions undertaken by the UNFPA country office – predominantly the training of service providers and the infrastructure improvements - were strategic as they were aligned with the government framework to improve access to and the quality of health care.

Judgment criterion 6.2

- Increased demand for and utilization of family planning services in UNFPA programme countries, particularly among vulnerable groups

UNFPA has supported the community-based distribution of commodities and demand creation for family planning services through advocacy, capacity development and the provision of family planning commodities, such as female condoms which UNFPA had introduced to Kenya.

Family planning is one of the five high impact interventions promoted by the Government of Kenya. UNFPA has supported the community-based uptake of family planning with a special focus on vulnerable groups and youth, peer education activities, advocacy, purchase of female condoms, and the training of community health extension workers (CHEW). CHEWs were involved in the distribution of contraceptives, health education, counseling and referral for family planning. Youth centers served as distribution centers for condoms and reproductive health/family planning information for youth.

UNFPA was responsible for the introduction of female condoms in Kenya. By 2011, their consumption had already risen to 300,000 condoms per year. As of 2011, 99 per cent of service delivery points in Kenya provided at least three modern contraceptive methods[49] (types of contraceptives were not specified). Male condoms were widely used and UNFPA support of the "Sure Condom" campaign led to an additional increase in the number of people reporting the use of condoms in their last sexual encounter.[50] The Naivasha district (one of the pilot sites for a "Centre of Excellence") reported the use

46. German Financial Cooperation.
47. Kenya is a stream three country for the Global Programme to enhance Reproductive Health Commodity Security and receives only emergency funds to avoid reproductive health commodity stock-outs that would otherwise occur. Annual Report 2010, Global Programme for Enhanced Reproductive Health Commodity Security (GRPHCS).
48. KMTC is the institution, which trains the largest number of nurses and clinical officers.
49. According to UNFPA Annual Report 2011.
50. UNFPA interview.

of the following family planning methods (in order of frequency): injectable contraceptives, pills, condoms, intrauterine contraceptive devices (IUCD) and implants.[51] UNFPA-funded programmes on fistula and female genital mutilation and cutting (FGM/C) created awareness of family planning among fistula survivors and victims of FGM/C.

Judgment criterion 6.3

- Improved access to contraceptives (commodity security)

Family planning is high on the Kenyan national agenda and the Government has created a dedicated budget line for contraceptives. UNFPA has supported government efforts to ensure commodity security through the direct purchase of condoms, and also by supporting improvements in the management and distribution of commodities. UNFPA has been reducing funding for contraceptives since 2008 with the intention of phasing it out completely by the end of 2012.

UNFPA has supported commodity security through the direct purchase of female and male condoms and by helping to the management and distribution of commodities. The UNFPA country office supported improved forecasting, worked to strengthen the logistics management information system (LMIS), and helped the procurement of trucks and equipment. In spite of this support and assistance from other development partners, the 2010 UNFPA country office annual report reported a national funding gap for family planning of 30 to 40 per cent, although it also noted the limited capacity of the government to absorb donor funding.

In recognition of these problems, in 2011 the Kenyan Government reassigned the responsibilities for family planning to the Ministry of Planning. The Ministry of Planning became responsible for sustaining the national commitment to family planning, as it was thought to be better positioned to advocate for reproductive health and family planning than the Ministry of Public Health and Sanitation. Commodity security was also reassigned from the Ministry of Public Health to the Kenyan Medical Supplies Agency (KEMSA).

UNFPA country office has continually reduced funding for contraceptives since 2008 and foresees no support for 2012.[52] However, at the time of this evaluation, the country office was in the process of soliciting funds to fill the 2010 funding gap.[53]

---

51. Naivasha district annual report 2010/2011.
52. Information from UNFPA country office.
53. COAR 2009, 'UNFPA has been able to leverage funds for condom procurement from the World Bank amounting to US$12 million over the next three years. 30 per cent of the funds will be used to procure female condoms.

4.1.7 Evaluation question 7: Sexual and reproductive health services – EmONC

Evaluation question 7

To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and emergency obstetric and newborn care services in programme countries?

Judgment criteria	Issues to assess
7.1. Increased access to emergency obstetric and newborn care services	How does UNFPA support functioning referral systems from home to tertiary care?
	Has UNFPA support improved the equitable distribution of emergency obstetric and newborn care facilities (affected the planning process for placement of emergency obstetric and newborn care facilities)?
7.2.Increased utilization of emergency obstetric and newborn care services	What mechanisms is UNFPA utilizing to mobilize the communities to support women in accessing emergency obstetric and newborn care; and to what effect?
	To what extent does UNFPA support research to evaluate barriers to emergency obstetric and newborn care?

Judgment criterion 7.1

- Increased access to emergency obstetric and newborn care services

The UNFPA country office has contributed to increased access to quality emergency obstetric and newborn care by providing technical and financial assistance to the Ministry of Health and its focus regions. The improved quality of services was expected to attract more clients for deliveries in health facilities. In 2007 the UNFPA-supported community midwifery programme was initiated Increased numbers of patients have been reported at UNFPA-supported facilities, but the refurbishment of the centers was not yet completed at the time of the evaluation.

UNFPA has supported the development of reproductive health strategy documents and the upgrading of health facilities since 2001. UNFPA initially financed trainings and equipment in nine districts (5th and 6th country programme) but in 2008 focused support on four project sites.

The Government of Kenya is strongly promoting skilled birth attendance, preferably at health facilities, with the support of community leaders. Together with UNFPA, the Department for Reproductive Health (DRH) in the Ministry of Health initiated a community midwifery programme in 2007 to enlist and support retired and unemployed midwives to assist women from their own communities during pregnancy, delivery and the postpartum period. The community midwives are considered to have a good understanding of the cultural beliefs and practices that limit utilization of health facilities for deliveries and are thought to be able to provide domiciliary obstetric care.[54] Following the distribution of best practices to key stakeholders, the UNFPA country office started community midwifery programmes in its four focus regions. After the first 18 months, the programmes had trained already over 70 midwives. The midwives receive continuing medical education and some referral backup (ambulance and mobile telephone sets). They do not receive delivery kits, as they are not meant to

54. This model has already been tried out in a Safe Motherhood Demonstration Project in Western Kenya on DFID initiative earlier in the decade and found to be promising.

assist in deliveries themselves, but instead are supposed to guide patients to clinics. As the new "Centers of Excellence" were still being refurbished at the time of this evaluation, a possible increased uptake of patients could not be assessed.

The safe motherhood initiatives have been strengthened to address the preventive components of obstetric fistula management (estimated at 3,000 new cases of obstetric fistula annually). Service providers have been trained and equipped to repair fistulas and to sensitize and mobilize the communities to access obstetric fistula services in order to address the current backlog of obstetric fistula clients, which is estimated by the Ministry of Health to consist of about 300,000 cases.

UNFPA and UNICEF also conducted a joint programme on improving access to maternal health services and decongesting provincial maternity hospitals and national referral hospitals in Nairobi. UNICEF supported staff training and provided equipment for newborn care while UNFPA equipped health facilities, strengthened referral systems by providing ambulances and communication facilities, and renovated buildings.

Judgment criterion 7.2

- Increased utilization of emergency obstetric and newborn care services

UNFPA intended to contribute to the increased utilization of emergency obstetric and newborn care (EmONC) services primarily by helping to improve the quality of these services and by making available additional service providers (community health extension workers (CHEWS), community midwives) that could mobilize women to seek out EmONC services in health centers/centers of excellence. However, as the refurbishment and construction of the four "Centers of Excellence" had not been finalized at the time of this evaluation, data were not yet available to assess the results.

Several activities of the UNFPA country office aimed at increasing the utilization of emergency obstetric and newborn care services. This included the community midwifery programme, the support of community health extension workers (CHEWs) in the communities of the "Centers of Excellence", the support to "Centers of Excellence" themselves, awareness campaigns and community mobilization. Implementing partners have trained community health workers and volunteers and have provided logistical support (transport and meals) during outreach and community mobilization campaigns. The strengthened link between retired community nurses and traditional birth attendants led the traditional birth attendants to mobilize women and to refer them to retired community midwives for skilled attendance at birth. At the community level, a growing number of women are delivering with skilled attendance.[55]

The UNFPA country office has supported the assessment of EmONC service delivery[56] and the mapping of health facilities in its focus regions to help the respective district medical offices determine the most appropriate location for new facilities

55. Interviews and data from UNFPA implementing partners.
56. Kenya Service Provision Assessment 2009.

4.1.8 Evaluation question 8: Results/evidence orientation of UNFPA maternal health support

Evaluation question 8

To what extent has the use of internal and external evidence in strategy development, programming and implementation by UNFPA contributed to the improvement of maternal health in its programme countries?

Judgment criteria[57]	Issues to assess
8.2. Consideration and integration of relevant maternal health/sexual and reproductive health evidence and results data during development of country strategies	What process have country offices gone through to use lessons from past support for future programming?
	What factors have prevented country offices from using lessons from past programming?
8.3. Result and evidence-based management of individual projects throughout project life	To what extent did UNFPA take into account capacity gaps in monitoring and evaluation (M&E) among its implementing partners and its own staff when developing its M&E calendars?

Judgment criterion 8.2

- Consideration and integration of relevant maternal health/sexual and reproductive health evidence and result data during development of country strategies

UNFPA has provided evidence at the global, regional and country level, which has been utilized in the planning of UNFPA Kenya country programmes. Recommendations from the evaluation of the country programme were integrated into the subsequent 7th UNFPA country support strategy.

A number of national policies and strategies have been developed with support of UNFPA and other development partners (see also evaluation questions one and two), based on political priorities of the Government of Kenya and utilizing findings of health assessments. The national government strongly directed the agenda, the location of implementation and the choice of implementing partners.[58] Currently this direction from the national government coincides with the UNFPA mandate.[59]

The UNFPA country programme has been developed in a consultative process. The country programme reflects the priorities of the Kenyan Government and the objectives of the United Nations Development Assistance frameworks (UNDAF). Various UNFPA-supported reproductive health assessments and national surveys have provided the evidence base for programming. The UNFPA country office also has conducted additional assessments with the Department of Reproductive Health in the Ministry of Health in the UNFPA target districts to collect data on a set of indicators.

A number of recommendations from the evaluation of the 6th country programme were considered in the development of the subsequent programme. For example, the decision to upgrade the capacity of the UNFPA country office for humanitarian assistance was based on lessons formulated during the review of the previous country programme. In 2011, the UNFPA

57. The previous Judgment criteria 8.3 was deleted; the assessment of the operationalization of UNFPA support in annual work plans was put together with the development of UNFPA country strategies (CPD/CPAP).
58. The NCAPD has been involved in the selection of the implementing partners for UNFPA who may be retained for a number of years and UNFPA has only limited control over them or the choice whom to select or to reject.
59. Information from UNFPA country office and government partners.

country office has instituted a tool to track the implementation of recommendations made by different stakeholders. It is meant to be used as "living" document and is supposed to feed into the next country programme cycle.

Judgment criterion 8.3

- Result and evidence-based management of individual projects throughout project life

An M&E officer has been responsible for monitoring and evaluation (M&E) related tasks in the UNFPA country office since 2007, such as supporting implementing partners in the set-up of monitoring systems for UNFPA-financed interventions. However, requiring implementing partners to use of separate UNFPA monitoring tools that differ in structure and content from tools used for the national health management information system has added to the workload of IPs and has led to the duplication of efforts.

UNFPA created a staff position in 2007 to handle M&E related tasks in the country office. However, the consolidation of data from the various projects represents a considerable workload, even for a full-time M&E officer, and other staff resources for monitoring and evaluation have not been available.

Implementing partners have received regular training in M&E, which helped in the set-up of monitoring systems for UNFPA-supported interventions. Monitoring activities have consisted of field visits, quarterly review meetings, and the annual review meeting with all implementing partners and representatives from the health administration in order to formulate lessons learnt.

The M&E frameworks of UNFPA, the UNDAF and national health management information system all differ substantially in terms of reporting. The specific requirements of UNFPA related to monitoring and the use of separate reporting tools have contributed to increased workload for implementing partners and have led to a duplication of efforts.

4.1.9 Evaluation question 9: Integrating maternal health into national policies and development frameworks

Evaluation question 9

To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its programme countries?

Judgment criteria	Issues to assess
9.2. Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process	What are the principal mechanisms by which UNFPA advocacy and awareness raising campaigns contribute to the development/revision/integration of maternal health issues into national policies?
	How coherent are efforts under the different relevant initiatives for maternal health policy making and policy dialogue: CARMMA, Maputo/maternal health road maps and UNFPA participation in SWAp fora?
9.3. Monitoring and evaluation of implementation of sexual and reproductive health/maternal health components of national policy framework and development instruments	To what extent have monitoring and evaluation tools that were developed with UNFPA support been adopted to monitor national maternal health/sexual and reproductive health policies and programmes?
	To what extent are maternal health indicators included in the monitoring (and evaluation) systems of national policies?

Judgment criterion 9.2

- Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process

UNFPA has used technical and financial assistance of surveys (such as the Kenyan Population and Housing Census (KPHC)) to ensure the availability of maternal health data and has worked with national ministries and department heads at district level to increase the utilization of maternal health data. In addition, UNFPA supported the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA). However, UNFPA did not follow up on its initial launch.

UNFPA has supported reproductive health policy-making through its participation in technical working groups, surveys and research. For example, UNFPA has lobbied successfully for the inclusion of maternal mortality indicators in the 2009 Kenyan Population and Housing Census (KPHC). The UNFPA country office used resources from the population and development programme component to train heads of district level departments in using data on the vulnerability of adolescent girls and young women to sexual reproductive health issues, HIV infection and gender-based violence for development planning at district level.

UNFPA supported the launch of the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA). However, the UNFPA country office did not consider CARMMA to be an initiative that needed to be followed up as relevant activities were already taking place.[60]

The UNFPA country office also has funded the secondment of technical assistants to the Ministry of Youth Affairs and Sports (MOYAS) and in the Ministry of Gender and Children Affairs for five years. The aim was to raise awareness and to contribute to the integration of youth and gender issues into national policies. The Government had committed itself to take over funding these positions at the conclusion of UNFPA support. However, at the time of this evaluation, the steps required to set up these positions had not yet been taken.

Judgment criterion 9.3

- Monitoring and evaluation of implementation of sexual reproductive health/maternal health components of national policy framework and development instruments

National frameworks frequently lacked detailed operational plans to guide their implementation or the necessary day-to-day management of the programmes associated with the policies.

UNFPA has supported the development of a range of reproductive and maternal health policies, standards and guidelines.[61] However, the UNFPA country office has not monitored the uptake and implementation of these policies. A number of the strategic frameworks that UNFPA had supported were never officially launched or disseminated. These delays were attributed to the lack of absorption capacity in the Ministry of Health (MoH) and the division of the former MoH into two separate Ministries in 2007; Ministry for Public Health and Sanitation and Ministry for Medical Services.[62]

Moreover, many of the existing strategies have not been translated into concrete plans and programmes that would ensure their implementation. At the time of this evaluation, several donors, including DFID, GIZ, DANIDA and UNICEF, had started to support the Department of Reproductive Health in developing a business plan for the reproductive health policy of 2007 to fill this gap. As of October 2011, UNFPA had not yet joined this initiative. However, participating development partners stated their interest in seeing UNFPA play a key role in this process, citing its ability to leverage the commitment of a broad range of partners as a valuable contribution

60. Information from the UNFPA country office.
61. Reproductive Health Policy, National Family Planning Policy, Kenya National AIDS Communication Strategy for Youth, Kenya National HIV/AIDS Strategic Plan and Plan of Action, National Sex Work Situational Analysis (Mapping), National Family Planning Guidelines, National Condom Policy and Strategy, National Guidelines for post Rape Management, National Guidelines for Prevention With Positives.
62. Information from UNFPA country office, development partners.

4.1.10 Evaluation question 10: Coherence of sexual reproductive health/maternal health support with gender and population and development support

Evaluation question 10

To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other programme areas?

Judgment criteria	Issues to assess
10.1. Linkages between programmes (Reproductive health with gender and population and development) established in intervention design	To what extent has UNFPA identified specific gender constraints as affecting and impeding reproductive health programme objectives at country level in its planning?
	How have these gender constraints been addressed in UNFPA programming?
	To what extent has population and development widened the utilization of its data by government, UNFPA and other partners in reproductive health/maternal health interventions?

Judgment criterion 10.1

- Linkages between programmes (Reproductive health with gender and population and development) established in intervention design

Gender has been integrated into all UNFPA reproductive health trainings and youth activities, and the UNFPA country office has helped to increase the capacity of the national Ministry of Gender and has supported the training of gender officers in other line ministries. Work on gender-based violence has been an integral part of the UNFPA reproductive health agenda in Kenya. This has included legal advocacy on female genital mutilation and cutting (FGM/C) that contributed to the passing of a national act against the practice.

The UNFPA country office has strongly advocated for the mainstreaming of gender into its programmatic work and has integrated gender aspects in all reproductive health activities, youth training and other interventions. Since the creation of the national Ministry of Gender in 2003, UNFPA has funded a technical assistant who is posted in the Ministry. In addition, the country office has supported the training of gender officers for all other line ministries. UNFPA implementing partners see the need to integrate gender and reproductive health even further, in particular with regard to the targeting husbands in campaigns on family planning and the prevention and treatment of fistula.

The UNFPA country office has considered gender based violence (GBV) relevant to maternal health and has supported it via a joint programme with UNICEF and, through humanitarian assistance,[63] UNFPA helped to establish an information management system for GBV in five pilot health facilities. It has also supported the development of standard operating procedures for GBV prevention and response. UNFPA also spearheaded the inclusion of gender-based violence indicators into the Kenyan Demographic and Health Survey (DHS) 2008/9. This was only the second time in the history of the Kenyan DHS that questions on domestic violence had been included.

63. Coordination of gender-based violence Emergency Response and Transition Project Evaluation Report 2010.

UNFPA also has been instrumental in advocating for legal reform on FGM/C, in cooperation with the Federation of Women Lawyers (FIDA), Kenya Women Parliamentarians (KEWOPA) and the Ministries of Health and Education. These efforts have resulted in the passing of a national act against female genital mutilation and cutting in October 2011.

However, the coordination of its work on youth has remained challenging for UNFPA. Three ministries are involved in this area at national level, i.e., the Ministries of Education, Gender, Youth and Health. Each of these Ministries has a different approach in supporting youth programming and none has assumed a clear leading role.

4.1.11 Evaluation question 11: Coherence between country, regional, global programmes

Evaluation question 11

To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?

Judgment criteria	Issues to assess
11.2. Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities	How time consuming was the recruitment of reproductive health expert into country offices? Could all required positions be filled?
11.3. Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level	What are specific contributions of regional programmes to supporting integration of maternal health into national frameworks/health system strengthening?

Judgment criterion 11.2

- Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities

Insufficient staffing has made it difficult for the UNFPA country office to adequately support its programmes and to play a catalytic role in the implementation of the 7th country programme and other UN programmes.[64] For example, UNFPA has lacked sufficient staff capacity to participate consistently in relevant technical working groups on maternal and reproductive health. Recruitment of new staff members has been a lengthy and extended process, with staff remaining on special service agreements for several years.

64. Information from Government and Development partners.

Judgment criterion 11.3

- Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level

The UNFPA Africa regional and sub-regional offices have provided on-demand support and also have offered the UNFPA country office staff opportunities to attend workshops on issues such as leadership management. The sub-regional office participated in M&E missions and has provided the country office with feedback for the annual work plan when requested.

4.1.12 Evaluation question 12: Coherence between country, regional, global programmes

Evaluation question 12

To what extent did UNFPA maternal health support contribute to UNFPA visibility in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?

Judgment criteria	Issues to assess
12.2. UNFPA leadership of maternal health advocacy campaigns at national level	What mechanissms or approaches has UNFPA used to advance its mission vis-á-vis the government and public (cite concrete examples in how UNFPA displays its convening power, where, how and who utilize its technical expertise, etc.)?

Judgment criterion 12.2

- UNFPA leadership of maternal health advocacy campaigns at national level

UNFPA has not fully utilized its potential for providing strategic and pro-active leadership in reproductive health and has not been recognized consistently for the contribution it has made in reproductive health. At the time of this evaluation, the UNFPA country office had finalized the development of a new communication strategy to better highlight the role and contributions of UNFPA in maternal health and reproductive health.

UNFPA has exercised strategic leadership in the areas of obstetric fistula and reproductive health commodity security.[65] UNFPA also has been able to leverage funds for the Kenyan Demographic and Health Survey and for other surveys in reproductive health.[66] However, UNFPA has been overshadowed by other, better-funded, development partners in most of its other programmes in different technical areas. This has increasingly been the case in fields of work such as family planning which had traditionally been core areas for UNFPA. Initiatives in reproductive health, such as the development of business plans for reproductive health, have typically been launched by other agencies. Additionally, UNFPA participation in technical, higher-level, coordination meetings has been limited due to insufficient staff capacity in the country office. This situation was likely to worsen with the devolution of resources to sub-national (county) level.[67] Both Government and development partners would like to see UNFPA provide stronger and more proactive leadership in reproductive health.

65. Interviews with Government and development partners.
66. Interview with Government.
67. As already expressed by government partners, development partners and the UNFPA country office.

UNFPA has not proactively pursued joint initiatives with other development partners. The joint UNFPA-UNICEF programme on HIV/AIDS was only put in place after DFID made joint programming and implementation arrangements a precondition for the provision of funds.

UNFPA communication efforts are considered as insufficient, even by the UNFPA country office itself. In a number of cases, UNFPA contributions have not been acknowledged, even though the country office was unofficially commended for its assistance. For example, UNFPA had frequently supported the review and development of reproductive health policies.[68]However, the final documents often failed to acknowledge the role of UNFPA in drafting the policies. UNFPA has found it challenging to establish its role even among UN and development partners, and efforts by the country office have not always been explicitly recognized. The UNDAF document, for example, contains multiple references on past and ongoing assistance to promote breastfeeding,[69] an initiative supported by UNICEF. However, the UNDAF makes no reference to the Kenyan census and the role that UNFPA has played in its implementation. Likewise, none of the four proposals from UNFPA for the Consolidated Appeal Process 2011[70] were included in the final document.

At the time of this evaluation, the UNFPA country office had just launched a newly designed communications strategy to address some of these challenges

68. The KDHS carries two logos, none of which belongs to the national institution: USAID and 'Kenyans and Americans to fight HIV/AIDS.
69. Led by UNICEF.
70. Led by OCHA; the health and protection sectors by WHO and UNHCR.

5. Conclusions[71]

Based on the findings on the issues to assess for each of the evaluation questions, the evaluation team for the country case study has drawn a number of some cross-cutting conclusions which are presented below. These are country-specific conclusions and are not to be confused with the conclusions of the MHTE final report. The conclusions presented in this section are based on the selective analysis of UNFPA maternal health support in Kenya only, and as such do not provide a judgment on the quality of UNFPA country programme in Kenya overall, which would only be provided by a comprehensive country programme evaluation.

5.1 Conclusions on UNFPA overall maternal health support in Kenya

1. UNFPA maternal health support has helped to shape the strategic focus of the Kenyan government on family planning and skilled birth attendance. [72]

    - UNFPA has established itself as a respected development partner of the Kenyan government. It has been a source of financial and technical support for the national road maps, other strategic documents and laws.
    - UNFPA has supported the generation and use of demographic and research data and information from monitoring and evaluation to improve the focus on maternal health by the government and development partners, and to improve the performance of its own programmes.
    - UNFPA has been able to leverage funds for contraceptives from development and governmental partners.
    - UNFPA has made a number of valuable contributions aimed at the improvement of skilled birth attendance in Kenya, such as models for improving access to maternal health services in its focus districts
    - UNFPA also addresses within its mandate potentially contentious topics, such as abortion, child marriage, female genital mutilation and cutting, as well as gender-based violence. These are currently issues included within the reproductive health agenda of the government.

2. UNFPA has targeted vulnerable groups by helping to empower communities to facilitate community access to reproductive health services.[73]

    - UNFPA conducts sensitization campaigns addressed at adolescents and supports integrated youth friendly services in its focus sites.
    - Specific areas of community involvement include training of community midwives and community health extension workers to increase access to skilled care, and addressing neglected areas of sexual and reproductive health, e.g. obstetric fistula, gender-based violence, adolescent and youth reproductive health, cervical cancer, etc.

---

71. Recommendations are not elaborated at this stage, as the overall conclusions to the evaluation questions will only be developed at the level of the final report to the MHTE evaluation.
72. Based on: Chapters 4.1 (relevance), 4.2 (harmonization), 4.4 (human resources for health), 4.7 (EmONC), 4.8 (evidence), 4.9 (frameworks).
73. Based on Chapters 4.1 (relevance) 4.8 (evidence).

- UNFPA is considered the lead agency for obstetric fistula in Kenya. It has provided training, equipment, community reinsertion mechanisms for affected women, and supported operations during specially organized weeks. The integration of obstetric fistula repair into the routine surgical care is currently underway, with the support of UNFPA.

3. UNFPA has shown flexibility in piloting new approaches to the specific context in Kenya. However, it has not allocated sufficient resources to monitor the performance of these interventions.[74]

    - UNFPA has supported the development of four clinical "Centers of Excellence" in remote rural areas in UNFPA focus districts. The location has been determined by a baseline survey that was carried out in cooperation with the district health department. However, neither UNFPA nor its partners have developed an appropriate tool to collect evidence on the performance of these Centers and to assess their viability before a national roll-out.

4. UNFPA has not fully utilized its potential to exert pro-active leadership in maternal health, partially due to limitations in its organizational capacity at the country level.[75]

    - Both the government and development partners would welcome a more pro-active approach from UNFPA in several areas in addition to its work on family planning and obstetric fistula. The government hopes to draw on the capacity of UNFPA to attract partners and to leverage funds and other commitments for maternal health. However, the UNFPA country office has lacked the capacity to fulfill such a pro-active role

74. Based on: Chapters 4.6 (family planning), 4.8 (evidence).
75. Based on: Chapters 4.2 (harmonization), 4.4 (human resources for health), 4.11 (internal coherence).

6. Annexes

6.1 Key data of Kenya

KENYA		
Summary statistics		
Region	2000	Eastern Africa
Currency	2008	Kenyan Shilling (KES)
Surface area (square kilometers)	2008	580367
Population (estimated, 000)	2008	38765
Population density (per square kilometer)	2008	66.8
Largest urban agglomeration (population, 000)	2007	Nairobi (3010)
Economic indicators		
GDP: Gross domestic product (million current US$)	2008	30552
GDP: Gross domestic product (million current US$)	2005	18769
GDP: Growth rate at constant 1990 prices (annual %)	2008	2.0
GDP per capita (current US$)	2008	788.1
GNI: Gross national income per capita (current US$)	2008	783.4
Gross fixed capital formation (% of GDP)	2008	16.8
Exchange rates (national currency per US$)	2008	77.71
Balance of payments, current account (million US$)	2008	-1978

CPI: Consumer price index (2000=100)	2008	250
Agricultural production index (1999-2001=100)	2008	134
Food production index (1999-2001=100)	2007	136
Labor force participation, adult female pop. (%)	2008	74.1
Labor force participation, adult male pop. (%)	2008	87.2
Tourist arrivals at national borders (000)	2006	1644
Energy production, primary (000 MT oil equivalent)	2007	394
Telephone subscribers, total (per 100 inhabitants)	2008	42.5
Internet users (per 100 inhabitants)	2008	8.7
Exports (million US$)	2008	5000.9
Imports (million US$)	2008	11127.8
Major trading partners (% of exports)	2008	Uganda (12.3), United Kingdom (11.0), United Rep. Tanzania (8.5)
Major trading partners (% of imports)	2008	United Arab Emirates (14.9), India (11.8), China (8.4)
Social indicators		
Population growth rate (avg. annual %)	2005-2010	2.6
Urban population (%)	2007	21.3
Population aged 0-14 years (%)	2009	42.8
Population aged 60+ years (women and men, % of total)	2009	4.4/3.8
Sex ratio (men per 100 women)	2009	99.9
Life expectancy at birth (women and men, years)	2005-2010	54.5/53.7
Infant mortality rate (per 1 000 live births)	2005-2010	63.9
Fertility rate, total (live births per woman)	2005-2010	5.0

Contraceptive prevalence (ages 15-49, %)	2003	39.3
International migrant stock (000 and % of total population)	mid-2010	817.8/2.0 (incl. refugees)
Refugees and others of concern to UNHCR	end-2008	1180088
Education: Government expenditure (% of GDP)	2005-2008	7.0
Education: Primary-secondary gross enrolment ratio (w/m per 100)	2005-2008	85.0/88.7
Education: Female third-level students (% of total)	2005-2008	36.3
Seats held by women in national parliaments (%)	2009	9.8
Environment		
Threatened species	2009	333
Forested area (% of land area)	2007	6.2
CO2 emission estimates (000 metric tons and metric tons per capita)	2006	12143/0.3
Energy consumption per capita (kilograms oil equivalent)	2007	100.0

Source: UN World Statistics Pocketbook

Figure 2: Map of Kenya

6.2 Data Triangulation

Table 4: Data and methodological triangulation – Maternal Health Thematic Evaluation

Evaluation question - Maternal Health Thematic Evaluation	Country Office	Nat. Government (MoH)	Sub-national Government	Civil Society	Development Partners	Implementing Partners[76]	Beneficiaries	Data collection methods
1. Relevance	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	Interviews, focus groups, evaluations, project reports, planning documents, etc
2. Harmonization, coordination, partnerships	▲ O	▲ O	▲ O	▲	▲ O	▲ O	▲	Interviews, evaluations, project reports, planning documents, etc
3. Community involvement and demand orientation	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	Interviews, evaluations, project reports, planning documents, etc
4. Capacity development – human resources in health (HRH)	▲ O	▲ O	▲	▲	▲ O	▲ O	▲ O	Interviews, evaluations, project reports, planning documents, etc
5. Maternal health in humanitarian contexts	▲ O	▲ O			▲ O			Interviews, evaluations, project reports, planning documents, etc
6. Sexual and reproductive health services – family planning	▲ O	▲ O	▲ O	▲	▲	▲ O	▲ O	Interviews, evaluations, project reports, planning documents, etc
7. Sexual and reproductive health services – EmONC	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	Interviews, focus groups, evaluations, project reports, planning documents, etc
8. Results/evidence orientation	▲ O	▲ O	▲ O	▲	▲ O	▲ O		Interviews, evaluations, project reports, planning documents, etc
9. Integrating maternal health in national policies and frameworks	▲ O	▲ O			▲ O	▲ O		Interviews, evaluations, project reports, planning documents, etc
10. Coherence of maternal health support with gender and population and development	▲ O	▲ O	▲ O			▲ O		Interviews, evaluations, project reports, planning documents, etc
11. Coherence between country, regional, global programmes	▲ O	O						Interviews, evaluations, project reports, planning documents, etc
12. Visibility	▲ O	▲ O	▲ O	▲ O	▲ O	▲ O	▲	Interviews, evaluations, project reports, planning documents, etc

▲= Primary Sources (Interviews, Focus Groups), O = Secondary Sources (Evaluations, project/intervention reports, planning documents, etc.)

76. Other than national Government (in particular the Ministry of Health (MoH)) or sub-national governments.

6.3 Data collection result matrix

Overview evaluation questions MHTE	
Evaluation question 1 To what extent is UNFPA maternal health support adequately focused on addressing the reproductive and maternal health needs of the vulnerable groups among countries and within countries?	
Judgment criteria	1.2. (Increased) availability of accurate and sufficiently disaggregated data for targeting most disadvantaged/vulnerable groups
	1.3. Needs orientation of planning and design of UNFPA supported interventions
Evaluation question 2 To what extent has UNFPA successfully contributed to the harmonization of efforts to improve maternal health, in particular through its participation in strategic and multi-sectoral partnerships at global, regional and national level?	
Judgment criteria	2.1. Harmonization in maternal health partnerships between UNFPA and United Nations (UN) organizations and World Bank (including H4+[77]) at global, regional and country level
	2.2. Harmonization of maternal health support through partnerships at country and South-South/regional
	2.3. UNFPA participation in partnerships for producing evidence for policy debates and definition and prioritization of coordinated operational maternal health research agenda

77. UNFPA, UNICEF, World Bank, World Health Organization (WHO), UNAIDS.

Evaluation question 3 To what extent has UNFPA support contributed to a stronger involvement of communities that has helped to increase current levels of demand and utilization of services, in particular through its partnerships with civil society?	
Judgment criteria	3.1. Government commitment to involve communities translated in sexual and reproductive health and maternal health strategies through UNFPA support
	3.2. Civil society organization involvement in sensitization on maternal health issues and facilitating community-based initiatives to address these issues supported by UNFPA
Evaluation question 4 To what extent has UNFPA contributed to the strengthening of human resources for health planning and human resource availability for maternal health?	
Judgment criteria	4.1. Development strengthening of national human resources for health (HRH) policies, plans and frameworks (with UNFPA support)
	4.2. Strengthened competencies of health workers in HIV/AIDS, family planning, obstetric fistula, skilled birth attendance and EmONC to respond to sexual and reproductive health/ maternal health needs
Evaluation question 5 To what extent has UNFPA anticipated and responded to reproductive health threats in the context of humanitarian emergencies?	
Judgment criteria	5.1. Inclusion of sexual and reproductive health in emergency preparedness, response and recovery plans
	5.2. Accessibility of quality EmONC, family planning and reproductive health/HIV services in emergency and conflict situations

Evaluation question 6 To what extent has the UNFPA contributed to the scaling up and increased utilization of and demand for family planning?	
Judgment criteria	6.1.Increased capacity within health system for provision of quality family planning services in UNFPA programme countries
	6.2. Increased demand for and utilization of family planning services in UNFPA programme countries, particularly among vulnerable groups
	6.3. Improved access to contraceptives (commodity security)
Evaluation question 7 To what extent has UNFPA contributed to the scaling up and utilization of skilled attendance during pregnancy and childbirth and EmONC services in programme countries?	
Judgment criteria	7.1. Increased access to EmONC services
	7.2. Increased utilization of EmONC services
Evaluation question 8 To what extent has UNFPA use of internal and external evidence in strategy development, programming and implementation contributed to the improvement of maternal health in its programme countries?	
Judgment criteria	8.2. Consideration and integration of relevant maternal health/sexual and reproductive health evidence and results data during development of country strategies
	8.3. Results- and evidence based management of individual interventions throughout project life

Evaluation question 9 To what extent has UNFPA helped to ensure that maternal health and sexual and reproductive health are appropriately integrated into national development instruments and sector policy frameworks in its programme countries?	
Judgment criteria	9.2. Maternal health and sexual reproductive health integration into policy frameworks and development instruments based on (UNFPA supported) transparent and participatory consultative process
	9.3. Monitoring and evaluation of implementation of sexual and reproductive/maternal health components of national policy framework and development instruments
Evaluation question 10 To what extent have UNFPA maternal health programming and implementation adequately used synergies between UNFPA sexual and reproductive health portfolio and its support in other programme areas?[78]	
Judgment criteria	10.1. Linkages established between programmes (reproductive health with gender and population and development) in intervention design

78. Gender (including female genital mutilation/cutting, gender-based violence, HIV-PMTCT (prevention of mother-to-child HIV transmission), population and development.

Evaluation question 11 To what extent has UNFPA been able to complement maternal health programming and implementation at country level with related interventions, initiatives and resources from the regional and global level to maximize its contribution to maternal health?	
Judgment criteria	11.2. Alignment of UNFPA organizational capacities at country level and the (intended) division of labor and delineation of responsibilities
	11.3. Enhancement/improvement of UNFPA country level programming and interventions through technical and programmatic support from global and regional level
Evaluation question 12 To what extent did UNFPA maternal health support contribute to the visibility of UNFPA in global, regional and national maternal health initiatives and help the organization to increase financial commitments to maternal health at national level?	
Judgment criteria	12.2. UNFPA leadership of maternal health advocacy campaigns at national level
	12.3. Increased financial commitments of partner governments to sexual reproductive health and maternal health

6.4 Focus Group report template

FOCUS GROUP	**Evaluation team member**		**Date**
	Topic/issues to be addressed	**Place**	
Participants (type, number, etc.)			
Issues discussed			
Findings			
Other Observations by evaluator			

6.5 List of documents consulted

TITLE	YEAR	TYPE OF DOCUMENT
DFID: Operational Plan 2011-2015	2011	Planning document
Family Health Options Kenya: Annual Report 2010	2010	Publication
Federation of Women Lawyers – Kenya: Micro Assessment of UN Implementing Partners	2010	Planning document
Frontiers in Reproductive Health, Population Council: Taking Critical Services to the Home. Scaling-up Home-based Maternal and Postnatal Care, including family planning, through Community Midwifery in Kenya	2008	Assessment report
GOK/Ministry of Gender, Children and Social Development/UNFPA: Monitoring and Evaluation Framework for Gender mainstreaming	2008	M&E Framework
GOK/Ministry of Gender, Children and Social Development/UNFPA: Training Manual on Gender Mainstreaming	2008	Training manual
GOK/Ministry of Health: Current Status of Reproductive Health Situation in the Nine UNFPA Focused Districts of Kenya	N/A	Assessment report
GOK/Ministry of Health: Reversing the Trends. The Second National Health Sector Strategic Plan of Kenya. Roadmap for Acceleration of Implementation of Interventions to Achieve Objectives of NHSSP II	2007	Planning document
GOK/Ministry of Health: Reversing the Trends. The Second National Health Sector Strategic Plan of Kenya 2005-2010	2005	Planning document
GOK/Ministry of Health/Ministry of Planning and National Development: Adolescent Reproductive Health and Development Policy	N/A	Planning document
GOK/Ministry of Health/University of Nairobi/Population Council: Safe Motherhood Demonstration Project Western Province	2004	Assessment report
GOK/Ministry of Planning and National Development, National Council for Population and Development (NCPD)/Ministry of Health, Division of Reproductive Health: Adolescent Reproductive Health and Development Policy	2003	Planning document
GOK/Ministry of Public Health and Sanitation, Naivasha District: Standard Progress Report, Quarter 1&2 2011. Access to Maternal and Newborn Health Services, AWP 2010/2011	2011	Progress report

GOK/Ministry of Public Health and Sanitation: Reversing the Trends. The Second National Health Sector Strategic Plan of Kenya. Strategic Plan 2008-2012	2008	Planning document
GOK/Ministry of Youth Affairs: National Plan of Action for the Health Component of the National Youth Policy 2006-2011	2007	Planning document
GOK/National Coordinating Agency for Population and Development (NCAPD)/Population Reference Bureau's (PRB) Informing Decision-makers to Act (IDEA) project: Kenya Population Data Sheet 2011	2011	Data sheet
GOK/UNFPA: 7th Country Programme Action Plan	2009-2013	Planning document
GOK/UNFPA: 7th Country Programme 2009-2013. Resource Mobilization Plan	2010	Planning document
GOK/UNFPA: 7th Country Programme. Annual Monitoring Plan	2009	Planning document
GOK/UNFPA: 7th Country Programme. Annual Programme Review Meeting, 6th – 11th December 2009	2009	Documentation
GOK/UNFPA: 6th Country Programme. End of Country Programme Evaluation. Management Response Tracking Tool	2010	Management report
GOK/UNFPA: 6th Country Programme 2004-2008. Final Evaluation Report	2008	Evaluation report
GOK/UNFPA: 6th Country Programme 2004-2008. Mid-Term Review	2007	Evaluation report
GOK/UNFPA: 6th Country Programme Framework of Indicators 2004-2008	2004	Planning document
GOK/UNFPA: 5th Country Programme 1997-2001. Final Evaluation Report	2002	Evaluation report
GOK/UNFPA: 5th Country Programme 1997-2001: The Reproductive Health Sub-Programme. Final Evaluation Report, Draft	2002	Evaluation report
GOK/UNFPA: 5th Country Programme 1997-2001: Data Sector. Final Evaluation Report	2002	Evaluation report
GOK/UNFPA: Country Programme Action Plan (CPAP)	2004-2008	Planning document
GOK/UNFPA: Country Programme Document (CPD)	2004-2008	Planning document
GoK/UNFPA/UNICEF: UNFPA-UNICEF Joint Programme on Female Genital Mutilation-Cutting: Accelerating Change. Annual Report 2010	2010	Publication

GOK/UNFPA/UNICEF Joint Programme on FGM-C: Baseline assessment/surveys for FGM-C interventions in selected Districts: Market, Kuria, Migori, Naivasha, and Mt. Elgon Districts	2010	Baseline survey report
GOK/UNFPA/UNICEF: UNFPA-UNICEF Joint Programme on Female Genital Mutilation-Cutting: Accelerating Change. Annual Report 2009	2009	Publication
GOK/UNFPA/UNICEF Joint Programme on FGM-C: Baseline survey for Samburu and Baringo Districts	2008	Baseline survey report
International Centre for Reproductive Health: Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula	2009	Evaluation report
Kenya Women Judges Association: Micro Assessment of UN Implementing Partner	2010	Assessment report
Maria Stopes Kenya: Micro Assessment of UN Implementing Partner	2010	Assessment report
MUMCOP: Micro Assessment of UN Implementing Partner	2010	Assessment report
National Commission on Gender and Development: Gender Based Violence Programme	2009	Assessment report
Population Council/GoK, Ministry of Health/UNFPA: Reproductive Health Needs Assessment in Eight Selected Districts of Kenya	2001	Assessment report
Population Council/UNFPA: Obstetric Fistula: Can Community Midwives Make a Difference? Findings from four districts in Kenya	2008	Assessment report
Presbyterian Church of East Africa (PCEA) Naivasha Parish Micro Assessment of UN Implementing Partner	2010	Assessment report
UN: The United Nations Development Assistance Framework Kenya 2009-2013	2008	Planning document
UNFPA: Annual Report 2010	2010	Publication
UNFPA: Annual Work Plans with Implementing Partners	2008, 2009, 2010	Planning documents
UNFPA: Country Annual Joint Reporting for the Thematic Funds: Fistula	2007, 2008, 2009, 2010	Management reports
UNFPA: Country Office Annual Reports (COAR)	2004, 2005, 2006, 2007, 2008, 2009, 2010	Management reports
UNFPA: Country Programme Performance Summary	2008	Management report

UNFPA: GoK/UNFPA 7th Country Programme Recommendations Tracking Tool – living document	2011	Management report
UNFPA: MHTF Results, Frameworks, Indicators, Baselines and Targets	2011	Report
UNFPA: Monitoring visit reports and trip reports	2006, 2007, 2008, 2009	Management reports
UNFPA: Review of the Country Annual Joint Reporting for Thematic Trust Funds	2009-2010	Report
UNFPA: Thematic Evaluation of National Programmes and UNFPA Experience in the Campaign to End Fistula. Kenya Desk Review (draft)	2009	Evaluation report
UNFPA/UNICEF/Christian Children`s Fund: A rapid assessment of gender-based violence during the post-election violence in Kenya	2008	Assessment report

6.6 List of people interviewed

Organization/Unit	Name	Position
Catholic Diocese of Nakuru, CDN	Vincent Omollo	Programme Coordinator
Catholic Diocese of Nakuru, CDN	Hannington O. Achila	Project Accountant
DFID	Antony Daly	Regional Maternal Health Advisor East Africa
Family Health Options Kenya	Simon Wahome	Head of Youth Programme
Family Health Options Kenya	Esther Mukelo	Programme Manager, Service delivery
FHOK Youth Friendly Center at Eastleigh	Angela Tatua	Centre Coordinator
Ministry of Medical Services, Kakamega Province	Dr. Ahindukha Quido	Provincial Medical Officer
Ministry of Gender	Protus Onyango	HOD – Gender Division
Ministry of Gender	Plorence Mburu	Assistant Director – Gender
Ministry of Gender	Mary Kabaru	Programme Officer FGM/ SGBV
Ministry of Gender	Christine Ochieng	P National Coordinator FGM/SGBV -UNFPA (Technical Advisor)
Ministry of Public Health and Sanitation, MOPHS	Dr. S.K. Sharrif	Director of Public Health and Sanitation
MOPHS	Dr. Bashir Issak	Head of Department of Public Health, DRH
MOPHS	Dr. Nakato Jumba	Programme Manager
MOPHS	Chris Malala	Accountant
MOPHS	Dr. Elizabeth Mgamb	District Medical Officer of Health, DMOH
MOPHS	Rose Odely	reproductive health Coordinator, Migori District Hospital

Ministry of Public Health and Sanitation, MOPHS, Naivasha	Dr. Peter Lenai	District Medical Officer of Health, DMOH, Naivasha
MOPHS, Naivasha	Emily Kilei	Nurse in charge - Karagita Health Centre
MOPHS, Naivasha	Daniel Githutha	Nurse in charge – Ndabibi Dispensary Centre of Excellence in reproductive health
Ministry of Youth Affairs and Sports, MOYAS	Josephine Mwangi	Principal Youth Development Officer -Social Development
MOYAS	Rose Mwongera	Principal Youth Development Officer - Health Section
Ministry of Youth Affairs and Sports, MOYAS, Migori	Alex Otieno Ojuga	District Youth Officer (Migori)
MUMCOP	Ismail Muchelule	Director
MUMCOP	Yusuf Omenda	Programme Coordinator
MUMCOP	Habiba Corodhia Mohamed	GBV Counselor
Nairobi City Council	Dr. Robert Ayisi	City Hall Director of Public Health
Nairobi City Council, Urban Slums Project	Mary Kimani	Project Coordinator
National AIDS and STI Control Programme, NASCOP	Dr. Nicholas Muraguri	Director
National Coordinating Agency for Population and Development, NCAPD	Dr. Boniface Omuga K'Oyugi	Chief Executive Officer
New Nyanza Provincial General Hospital	Dr Paul Mitei	HOD – Gynecological ward
New Nyanza Provincial General Hospital	Dr. Dan Raburu	Deputy Medical Superintendent
Riruta Health Centre	Wanjiru Kimiti	In charge of facility and reproductive health focal person
UNFPA	Dr. Alexander Illyin	Deputy Representative

UNFPA	Dr. Stephen Seif Wanyee	Assistant Representative, reproductive health
UNFPA	Dr. Geoffrey Okumu	Programme Officer – reproductive health, HIV/ AIDS
UNFPA	Batula Abdi	National Programme Officer
UNFPA	Zipporah Gathiti	M&E Officer
UNFPA	Matilda Musumba	Humanitarian Officer
UNFPA	Stephen Malai	Communications Officer
UNICEF	Dr. Chris Auma	PMTCT

6.7 Overview of UNFPA interventions in Kenya (2008-2011)

Annual Work Plans (AWP)

Component of country programme	Implementing partner	Project/programme titles	Volume in US$ (contracted) from UNFPA	Year
Reproductive Health	Catholic Diocese of Nakuru, CDN	Accelerating the Attainment of MDG five and six including ICPD Goals (focus on family planning, obstetric fistula, FGM-C)	100,000	2010
Reproductive Health	Catholic Diocese of Nakuru, CDN	Accelerating the Attainment of MDG five and six including ICPD Goals (focus on family planning, obstetric fistula, FGM-C)	129,848	2009
Reproductive Health	City Council Nairobi, Urban Slum Development Project	Accelerating the Attainment of MDG five and six including ICPD Goals (focus on EMONC, midwives, youth centers)	200,000	2010
Reproductive Health	Coast Development Authority	Scaling up of farmers field schools, reproductive health project: Kilifi District (focus on maternal health, family planning, obstetric fistula, GBV)	30,000	2010
Reproductive Health	Coast Development Authority	Scaling up of farmers field schools, reproductive health project: Kilifi District (focus on reproductive health, HIV and GBV)	30,000	2009
Reproductive Health	Coast Development Authority	Emergency Reproductive Health Response for Victims of the Kenya Political Conflict (Coast)	30,000	2008

Reproductive Health	Council of Imams and Preachers of Kenya	Accelerating the Attainment of MDG five and six including ICPD Goals (focus on family planning, obstetric fistula, FGM-C)	50,000	2010
Reproductive Health	Council of Imams and Preachers of Kenya	Accelerating the Attainment of MDG five and six including ICPD Goals (focus on family planning and obstetric fistula)	58,500	2009
Reproductive Health	Council of Imams and Preachers of Kenya	Culturally sensible BCC	46,000	2008
Reproductive Health	Family Health Options Kenya (FHOK)	Sexual Reproductive Health and Rights country programme	80,000	2010
Reproductive Health	Family Health Options Kenya (FHOK)	Sexual Reproductive Health and Rights country programme	76,000	2009
Reproductive Health	Family Health Options Kenya (FHOK)	Integrated Reproductive Health Services for four Focus Districts (Youth Centers)	30,000	2008
Reproductive Health	International Center for Reproductive Health Kenya (ICRH-K)	Promoting alternative means of livelihoods to reduce STI/HIV among most-at-risk populations in Kilifi and Mtwapa	50,000	2010
Reproductive Health	Kenya Red Cross	Towards improved sexual reproductive health services in development and emergency context in Kenya	52,947	2009
Reproductive Health	Maria Stopes Kenya	Increasing access to safe motherhood and family planning and HIV/ AIDS services through community midwifery and outreach	100,000	2010
Reproductive Health	Maria Stopes Kenya	Increasing access to safe motherhood and family planning and HIV/ AIDS services through community midwifery and outreach	254,262	2009

Reproductive Health	Maria Stopes Kenya	Community mobilization to increase access to obstetric fistula and safe motherhood services including community midwifery	20,033	2008
Reproductive Health	Ministry of Planning and National and Development and Vision 2030, Rural Planning Directorate	Building DDO`s capacity for M&E in four Focus Districts of UNFPA programmes	40,000	2010
Reproductive Health	Ministry of Planning and National and Development and Vision 2030, Rural Planning Directorate	Building DDO`s capacity for M&E in four Focus Districts of UNFPA programmes	40,000	2009
Reproductive Health	Ministry of State for Youth Affairs	(Promoting family planning and Youth Centers)	220,466	2010
Reproductive Health	Ministry of State for Youth Affairs	(Promoting National Youth Policy, family planning and Youth Centers)	229,619	2009
Reproductive Health	Ministry of Youths and Sports	Reproductive Health for four Focus Districts	100,000	2008
Reproductive Health	Mumias Muslim Community Programme, MUMCOP	(Prevention and management of obstetric fistula and improve access of young people to integrated sexual reproductive health and HIV prevention)	100,000	2010
Reproductive Health	Mumias Muslim Community Programme, MUMCOP	(Prevention and management of obstetric fistula and improve access of young people to integrated sexual reproductive health and HIV prevention)	112,000	2009
Reproductive Health	National AIDS Control Council (NACC)	Accelerating the Attainment of MDG five and six including ICPD Goals (focus on HIV)	285,000	2009
Reproductive Health	National AIDS/STIs Control Programme, NASCOP	Accelerating the Attainment of MDG five and six including ICPD Goals (focus on condoms)	160,000	2009

Reproductive Health	National Quality Control Laboratory for drugs and medical devices, NQCL	(Comprehensive condom programming and scaling up HIV and STI prevention skills and services)	29,627	2009
Reproductive Health	Presbyterian Church (PCEA) Naivasha	Accelerating the Attainment of MDG five and six including ICPD Goals (focus on community outreach and training, counseling)	46,500	2009
Reproductive Health	UNFPA Kenyan country office	Joint UNFPA/UNICEF Trust Fund Programme: Abandonment of Female Genital Mutilation/ Cutting: Towards Social Change	164,956	2009
Reproductive Health	UNFPA Kenyan country office	Joint UNFPA/UNICEF Trust Fund Programme: Abandonment of Female Genital Mutilation/ Cutting: Towards Social Change	200,000	2008
Reproductive Health		**Total**	**3,065,758**	
Population and Development	Kenya Media Network on Population and Development (KEMEP)	Dissemination of quality gender-sensitive population and reproductive health data	60,000	2010
Population and Development	Kenya Media Network on Population and Development (KEMEP)	Women`s Rights text awareness	60,000	2009
Population and Development	Kenya Women Parliamentary Association (KEWOPA)	Transforming institutions and procedures in Parliament through women parliamentarians to promote enactment of gender legislations and gender mainstreaming in laws and policies (incl. increase of resource allocation for DRH)	47,452	2009
Population and Development	Ministry of Gender and Children Affairs	Coordination of population policy implementation	50,000	2008
Population and Development	Ministry of Planning and National and Development and Vision 2030, M&E Directorate	Building M&E capacity in West Nairobi, Kilifi, Migori and Naivasha	20,000	2010

Population and Development	National Bureau of Statistics	Data collection and data base development	421,765	2009
Population and Development	National Bureau of Statistics	Data collection and data base development	443,000	2008
Population and Development	National Coordinating Agency for Population and Development (NCAPD)	Enhancing capacity for coordinating, monitoring and evaluating PD programmes	305,000	2010
Population and Development	National Coordinating Agency for Population and Development (NCAPD)	Accelerating the Attainment of MDG five and six including ICPD Goals (focus on integration of population variables into sectoral policies)	20,707 KSH (ffiUSD250)	2009
Population and Development	National Coordinating Agency for Population and Development (NCAPD)	Population Programme Coordination	475,823	2008
Population and Development	Tasaru Ntomonok Initiative	Coordination of Population Policy implementation (focus on FGM-C)	50,000	2008
Population and Development		**Total**	**1,933,290**	
Gender	Federation of Women Lawyers Kenya (FIDA)	Enhancing Gender equality (focus on legislation)	120,093	2010
Gender	Federation of Women Lawyers Kenya (FIDA)	Enhancing Gender equality (focus on legislation)	120,000	2009
Gender	Kenya Women Parliamentary Association (KEWOPA)	(Advocacy for Legislation that promotes gender equality principles)	50,000	2010
Gender	Maendeleo Ya Wananwake Organization	Gender equity (focus on emergency and FGM-C)	51,000	2009
Gender	Ministry of Gender, Children and Social Development	Capacity development for gender mainstreaming	110,000	2010
Gender	Ministry of Gender, Children and Social Development	Capacity development for gender mainstreaming	90,000	2009

Gender	National Commission on Gender and Development (NCGD)	Mainstreaming of gender in Legislation (focus on GBV)	132,172	2010
Gender	National Commission on Gender and Development (NCGD)	Promoting Gender equality through gender responsive Legislation and community involvement (focus on GBV)	160,000	2009
Gender	Women's Empowerment Link (WEL)	Promoting gender equality through community involvement	60,045	2009
Gender	Women Judges Association	Enhancing gender equality	30,000	2010
Gender	Women Judges Association	Protecting human rights through structuring effective access to justice and remedies to address gender based violence	31,468	2009
Gender		**Total**	**954,778**	
Reproductive Health/Gender/ Population and Development	Ministry of Finance	Accelerating the Attainment of MDG five and six including ICPD Goals	57,835	2009
Reproductive Health/Gender/ Population and Development	UNFPA Kenyan country office	Programme Coordination and Assistance	758,200	2009
Reproductive Health/Gender/ Population and Development	UNFPA Kenyan country office	Programme Coordination and Assistance	630,000	2008

Note: These are not complete expenditures for the mentioned period, but just an indicative overview about the activities within the three components Reproductive Health, Population and Development and Gender based on the available annual work plans.

Source: Annual work plans Kenya

Table 6: UNFPA Interventions in Kenya 2004-2010 (based on ATLAS data)

Time period	Project ID	Project Title	Budget	Expenditure
		Accelerating the attainment of	727,022.62	722,593.29
2009 - 2010	KEN7R23A	ACCESS TO HIV&AIDS & STI PREVE	220,071.16	220,917.65
2009 - 2010	KEN7R11G	INCREASED ACCESS TO maternal and newborn health SERVIC	2,060,873.96	1,621,160.69
2009 - 2010	KEN7R13D	INCREASED DEMAND FOR HIV/STI S	86,743.62	86,743.60
2004 - 2007, 2009 - 2010	KEN98P01	INTEGRATED Reproductive Health FOR PASTORALISTS	9,707.49	4,310.63
2008 - 2010	KENM0809	KEN BSB MANAGEMENT	2,757,626	2,828,213.81
2009	KEN7R12D	Monitoring the attainment of M	15,000	14,722.77
2009 - 2010	KEN7R22A	PREVENTION AND MANAGEMENT OF O	279,628.38	278,308.18
2009 - 2010	KEN7R23B	PROMOTING ALTERNATIVE MEANS OF	220,345.60	186,114.20
2009 - 2010	KEN7R22B	PROMOTING INTEGRATED family planning/STI/HI	314,317.23	309,622.14
2009 - 2010	KEN7R11K	PROVISION OF sexual reproductive health/GBV/ HIV&AIDS	207,247.10	205,021.33
2004 - 2007	KEN98P03	R.H.NBI.INFORMAL SETTLEMENTS	29,980.90	14,384.61
2009 - 2010	KEN7R22Z	REDUCING HIV AMONG THE YOUTH A	289,620.67	251,480.61
2004 - 2007, 2009 - 2010	KEN98P04	Reproductive Health. ADVOCACY FOR YOUTH	55,223.20	33,708.79
2009 - 2010	KEN7R11A	SAFE MOTHERHOOD/ family planning/HIV SERV. T	323,757.90	176,009.17

2009 - 2010	KEN7R22C	Scaling up family planning/ HIV&AIDS service	42,834.44	42,314.73
2010	MOZ07P08	Support to adolescent sexual and reproductive health in Gaza	0	0
2004 - 2007	KEN99P03	YOUTH R. HEALTH EDUCATION	5,978.05	2,499.77
		Total	**7,645,978.32**	**6,998,125.97**

Source: ATLAS data