Independent mid-term evaluation of the UNFPA Supplies Partnership 2021–2030

Case Study

Kenya

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Cover photo: After receiving information about family planning from a nurse in Luanda, 24-year-old Ester Nhambe chose to receive a self-injectable hormonal contraceptive that provides protection against pregnancy for three months. © UNFPA Angola/Noriko Hayashi.

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Foreword

The UNFPA Supplies Partnership, established in 2007, is a flagship global health initiative dedicated to strengthening health systems by ensuring equitable access to quality-assured modern contraceptives and life-saving maternal health medicines for women and girls in the world's 54 low-income countries. Directly supporting the implementation of the UNFPA strategic plan, the Partnership is crucial in reducing unintended pregnancies, lowering maternal risks and promoting sustainable development. Now operating in its third phase (2021–2030), the Partnership is strengthening health systems by improving supply chains, developing stronger policies , and diversifying financing to reach the last mile and leave no one behind.

The independent mid-term evaluation of the Partnership (Phase III) comes at a critical moment, serving as both an accountability instrument and a learning tool to ensure the Partnership remains on track to achieve its goals by 2030. It provides an independent assessment of the Partnership's performance in expanding access to modern contraceptives and life-saving maternal health medicines for women and girls, particularly those in hard-to-reach settings. The evaluation also assesses the Partnership's contribution to strengthening health systems for long term sustainability and scale.

The evaluation found that the current phase of the Partnership has positioned UNFPA well as a catalytic global actor. The introduction of innovative financing tools, including Compacts, the Match Fund, and the Supplies Results and Accountability Tool (SRAT), is driving momentum toward sustainable domestic financing and enabling more tailored country engagement. The evaluation also finds that UNFPA has a strong position within the global SRHR landscape, reinforcing its role as both a convener and a strategic advocate. However, the evaluation also reveals that limited attention to health systems strengthening (HSS) and demand-side interventions persist and despite strong country demand for HSS, there is insufficient capacity to drive full systems transformation. Additionally, progress remains uneven across countries due to differences in political will, fiscal space, and institutional capacity.

To accelerate its progress, the evaluation recommends that the Partnership reflect further on its country classification in light of political, economic, and health contexts and policies. The Partnership should strengthen its engagement in humanitarian contexts, particularly in enhancing procurement, supply chain management, and last-mile delivery mechanisms where applicable. The evaluation also recommends diversifying the Partnership's funding sources and strengthening domestic resource mobilization in programme countries.

The evaluation offers a strong assessment of where the Partnership stands today and the direction it should take to achieve its 2030 goals. I am confident that the insights from this evaluation, along with its six actionable recommendations, provide a clear path for strengthening the Partnership, and ultimately enabling more women and girls to exercise their reproductive rights, strengthening health systems to deliver quality services and ensuring countries can sustain equitable access to life-saving reproductive health supplies

Marco Segone
Director
UNFPA Independent Evaluation Office

Acknowledgements

This evaluation would not have been possible without the invaluable inputs and support from a wide range of stakeholders, both within and outside UNFPA. The Independent Evaluation Office and evaluation team is deeply appreciative of the considerable time and contributions of those from the Programme Division, notably the UNFPA Supplies Partnership team under the Sexual and Reproductive Health and Rights Branch, the Supply Chain Management Unit, as well as those from the Partnership's Steering Committee, who generously shared their knowledge. This evaluation also benefited from the invaluable insights of all technicians who comprised the Evaluation Reference Group. Finally, we are extremely grateful to the staff in the country offices in Cameroon, Democratic Republic of Congo (DRC), Honduras and Kenya for their crucial contribution to the work of the evaluation team. They played a key role in facilitating the extensive data collection, which involved documentary review, interviews, site visits, group discussions and a survey to obtain the perspectives of all stakeholders, including those receiving support from the programme.

Louis Charpentier, Ph.D.
Evaluation Manager, UNFPA Independent Evaluation Office

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Abbreviations and Acronyms

AGYW	Adolescent girls and young women
ANC	Antenatal care
ART	Antiretroviral therapy
ASAL	Arid and semi-arid lands (10 counties in north of Kenya)
ASRH	Adolescent sexual and reproductive health
AYP	Adolescents and young people
BMGF	Bill and Melinda Gates Foundation
BTL	Bilateral tubal ligation
CBD	Community-based distributor
CBO	Community-based organization
CHAI	Clinton Health Access Initiative
CHP	Community health promoter
CIP	Costed Implementation Plan
COC	Combination oral contraceptive pills
COMT	County order management team
CPG	Consensus Planning Group
CPR	Contraceptive prevalence rate
CYP	Couple years protection
DESIP	Delivering Sustainable and Equitable Family Planning (DESIP) programme (of FCDO)
DiC	Drop-in centre
DMPA	Depot medroxyprogesterone acetate (also known as DepoProvera)
DMPA-IM	Depot medroxyprogesterone acetate-intramuscular
DMPA-SC	Depot medroxyprogesterone acetate-sub cutaneous
DoH	(County-level) Department of Health
DPHK	Development Partners for Health in Kenya
eCHIS	Electronic Community Health Information System
ESA	East and Southern Africa
EWAS	Early Warning and Alert System
FBO	Faith-based organization
FCDC	Frontier Counties Development Council (for the ASAL area)
FCDO	(UK) Foreign, Commonwealth and Development Office
FGD	Focus group discussion
FGM	Female genital mutilation
FSW	Female sex worker
GBV	Gender-based violence
GDP	Good distribution practices
GHI	Global Health Initiatives
GSP	Good storage practices

HCW	Healthcare worker
HFA	Health facility assessment
HMIS	Health Management Information System
HRBA	Human rights-based approach
HRD	Humanitarian Response Division (of UNFPA)
HRH	Human resources for health
HSS	Health system strengthening
ICRH-K	International Centre for Reproductive Health - Kenya
iLMIS	Integrated Logistics Management Information System
IP	Implementing partner
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine device
KEMSA	Kenya Medical Supplies Authority
KHIS	Kenya Health Information System
LARC	Long-acting reversible contraceptive
LMA	Last Mile Assurance
LMIC	Lower middle-income country
LMIS	Logistics Management Information system
LNOB	Leaving no one behind
MAV	Matching Assistance for Voluntary Family Planning (funding stream)
MCH	Maternal and child health
mCPR	Modern contraceptive prevalence rate
MISP	Minimum Initial Service Package
MMR	Maternal mortality rate
MNCH	Maternal, neonatal and child health
MoH	Ministry of Health
MoU	Memorandum of understanding
MSI	Marie Stopes International
MTEF	Mid-Term Expenditure Framework
NAYA	Network for Adolescents and Youth of Africa
NCPD	National Council for Population and Development
NHIF	National Health Insurance Fund
NLU	New and lesser used (products)
NOMT	National order management team
PAC	Post-abortion care
Partnership	UNFPA Supplies Partnership

POD	Proof of delivery
PPB	Pharmacy and Poisons Board
PPP	Public-private partnership
PS	Principal Secretary
PSK	Population Services Kenya
PWD	Person with disability
QSR	Quarterly stock report
RHNK	Reproductive Health Network Kenya
RMNCAH	Reproductive, maternal, neonatal, child, adolescent Health
SCM	Supply chain management
SCMU	Supply Chain Management Unit (of UNFPA)
SCOMT	Sub-county order management team
SDG	Sustainable Development Goal
SHIF	Social Health Insurance Fund
SRAT	Sustainability Readiness Assessment Tool
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TA	Transformative action
TMA	Total Market Approach
ToT	Training of trainers
TWG	Technical working group
UHC	Universal Health Care
UK	United Kingdom
VAN	Visibility and Analytics Network
VSC	Voluntary surgical contraception

Executive summary of the overall mid-term evaluation of the Supplies Partnership (2021-2030)

Background

The UNFPA Supplies Partnership (hereafter referred to as the Partnership) is a key global flagship programme, ensuring sustainable, equitable access to sexual and reproductive health (SRH) commodities, including modern contraceptives and life-saving maternal health medicines. It plays a central role in supporting countries with the greatest needs to address the unmet demand for family planning and preventable maternal mortality, aligning closely with global commitments to universal health coverage, gender equality, and the Sustainable Development Goals (SDGs). As a key driver of the UNFPA Strategic Plan, the Partnership directly contributes to achieving two of the three transformative results: eliminating unmet need for family planning and ending preventable maternal mortality.

Phase III (2021–2030) builds upon the achievements and lessons of previous iterations by advancing a more structured, sustainable and country-owned approach to reproductive health commodity security (RHCS). It represents a strategic shift from a programme-based model to a more inclusive partnership approach. It emphasizes government ownership, financial sustainability, and last mile delivery, with a broader mandate that incorporates health systems strengthening (HSS), strategic procurement, market shaping and enhanced governance. The Partnership operates across 54 countries, guided by four strategic objectives: SO.1 – improving availability and choice; SO2 – strengthening supply chains; SO3 – increasing government commitment and domestic financing; and SO4 – enhancing operational effectiveness and efficiency.

Purpose and scope of the evaluation

The purpose of this mid-term evaluation is to assess the progress, effectiveness and strategic positioning of the Partnership and to inform any necessary adjustments for the successful continued implementation and achievement of its goals up to and including 2030. The evaluation has four main objectives: (1) assess the adequacy of the theory of change and causal logic; (2) examine progress across the four strategic objectives; (3) identify good practices and factors that contributed to or hindered results; and (4) provide evidence to enhance decision-making and implementation moving forward.

The evaluation covers the implementation period from 2021 to 2024, across all 54 Partnership countries. The evaluation's intended users include the UNFPA Sexual and Reproductive Health and Rights (SRHR) Branch, country and regional offices, the Partnership's Steering Committee, donors, governments, civil society partners, and other United Nations agencies.

Methodology

The evaluation adopted a theory-based approach grounded in contribution analysis. A reconstructed theory of change was used to guide the evaluation framework, encompassing causal pathways, assumptions, and interdependencies among the strategic objectives. A mixed-methods design was employed, integrating quantitative and qualitative data from 258 key informant interviews, a survey from 241 respondents across 54 countries, document and data reviews (194 documents), and seven country case studies (four field-based and three desk-based). In addition to assessing programme design, performance, and governance, two thematic studies focused on (1) the Match Fund co-financing mechanism, and (2) the Last Mile Assurance (LMA) process. Ethical considerations were embedded throughout, adhering to UNEG standards. Data triangulation ensured the credibility of findings, while participatory methods enhanced ownership and learning.

Main findings

The evaluation highlights significant strengths, persistent challenges, and emerging opportunities across the four strategic objectives of the Partnership. The main findings are categorized into seven areas: design, country eligibility, governance and strategic alignment, strategic procurement,

strengthening supply chains, enhancing domestic resource mobilization and the role and added value of the Partnership.

1. Design: Partnership model, sustainability and equity

Phase III of the UNFPA Supplies Partnership introduced a deliberate transition from a centrally managed programme model to a strategic partnership approach grounded in mutual accountability, sustainability and government ownership. This change is widely recognized and appreciated by stakeholders across all levels of implementation. The rebranding from "Supplies Programme" to "Supplies Partnership" reflects a broader vision, reinforcing the notion of shared responsibility among UNFPA, partner governments, donors and implementing actors.

New design elements and financing tools, such as the Compacts, Match Fund, and the Sustainability Readiness Assessment Tool (SRAT), were identified as critical to operationalize the Partnership's focus on domestic financing. These tools have supported more tailored engagement at the country level and helped initiate a shift in thinking from donor-driven inputs to co-financed solutions. These tools offer significant potential, yet their uptake and effective use remain inconsistent. For instance, while most eligible countries have signed Compacts to signal commitment to sustainable financing, some lack the institutional readiness or fiscal flexibility to fully implement these tools.

The shift towards sustainable financing and country-led prioritization has had both positive benefits and introduced questions within the resource allocation model. The inclusion of new countries broadened geographic reach and equity, but it has also diluted available resources and introduced complexity in balancing long-standing needs with new country demands. Many stakeholders noted that the design does not adequately consider factors such as quality of care, social norms, and health workforce capacity. While these areas fall outside the Partnership's direct focus on commodity provision, they are essential to achieving sustainable and equitable health outcomes and ignoring them may limit the Partnership's overall impact.

2. Country eligibility, equity, and scope of coverage

In its phase III, the Partnership offers a more structured and transparent approach to country eligibility and classification compared to previous phases. The use of quantifiable indicators – GNI per capita, modern contraceptive prevalence rate (mCPR), and maternal mortality ratio (MMR) – has improved clarity and predictability. Initially conceived as a transitional measure, the "carryover" group of countries remains poorly understood and inconsistently applied, in part because the Partnership was unable to implement the planned exit strategy envisioned for phase III due to factors such as the unprecedented impact of the COVID-19 pandemic and the deprioritization of resources.

The inclusion of 54 countries has placed pressure on the Partnership's capacity to deliver high-quality, context-sensitive support across a highly diverse portfolio. While inclusivity is valued, geographic expansion could compromise depth, particularly in fragile or complex operating environments. Meanwhile, stakeholders in carryover countries expressed uncertainty regarding their status, the duration of their inclusion, and the implications for future support.

3. Governance, partnership and strategic alignment

Governance arrangements under phase III have become more inclusive and participatory. The Steering Committee and its sub-committees were established to provide strategic oversight, financial accountability, and technical guidance. Stakeholders generally perceived these structures as effective in fostering transparency and legitimacy. The inclusion of bilateral donors, implementing countries, civil society organizations, and private sector donors in governance bodies reflects a balanced and deliberate effort to support joint leadership.

Gaps remain in the operationalization of governance roles. For example, the flow of information between Steering Committee decisions and field-level implementation is inconsistent. There are also concerns about limited engagement of civil society and insufficient mechanisms for integrating country-level voices into strategic planning. Country-level stakeholders, in particular, reported that while governance structures exist at a global level, these do not always translate into participatory processes in-country.

Internally, the Partnership aligns well with UNFPA's broader strategic direction. Its coherence with the UNFPA Strategic Plan, Family Planning Strategy, and Humanitarian Supplies Strategy is evident in strategic documents and operational plans. At the operational level, integration with other UNFPA streams, such as gender-based violence, maternal health, and youth programming, is more limited and highly context-dependent. Externally, the Partnership's alignment with global health initiatives (for example, the Global Financing Facility for Women, Children and Adolescents (GFF), Global Fund and Gavi) remains informal and opportunity-driven rather than institutionalized.

4. Strategic procurement and adaptive supply solutions

UNFPA continues to maintain its comparative advantage as a global leader in reproductive health supply and market shaping, offering economies of scale, quality assurance and global price transparency. Stakeholders emphasize the reliability and credibility of UNFPA procurement mechanisms, including pooled procurement, long-term agreements, and support for third-party procurement services. These mechanisms have contributed to market shaping, especially for long-acting reversible contraceptives (LARCs), emergency contraception and maternal health medicines.

In humanitarian contexts, UNFPA remains a trusted partner for the delivery of emergency reproductive health kits and individual products. However, there are persistent challenges which include a lack of clarity or agreement on the Partnership's role in crisis response, as well as operational challenges such as procurement delays. In addition, there is also a lack of guidance on adapting procurement modalities for sudden-onset crises.

5. From diagnostics to delivery: strengthening supply chains

One of the most notable areas of progress under phase III has been in supply chain strengthening. Countries report improved visibility and efficiency in logistics through the rollout of eLMIS platforms, inventory management systems and routine diagnostics. The Partnership's investment in capacity building for logistics professionals and data managers has supported better forecasting, reduced wastage and improved stock management.

The LMA framework has been particularly instrumental in tracking delivery outcomes and enhancing accountability. However, its implementation remains uneven. In some countries, LMA has been integrated into national systems and has supported evidence-based decision-making. In others, it is perceived as donor-driven and resource-intensive and lacks ownership.

6. Incentivizing domestic financing for sustainability

The Partnership's emphasis on domestic resource mobilization has been well received and aligns with broader global movements towards country-led health financing. Tools like the Compact and the Match Fund have incentivized co-investment and sparked dialogue on sustainable financing within ministries of health and finance.

Nonetheless, progress remains uneven as political will, fiscal space and institutional capacity vary widely. Some countries have shown promising results in increasing domestic allocations for reproductive health commodities, while others continue to rely heavily on donor contributions. There is also limited data availability on government expenditures, which constrains monitoring of domestic financing commitments.

At the donor level, the Partnership benefits from a more diversified funding base compared to previous phases but also faces a concerning decline in overall contributions during phase III. This decline is attributed to broader geopolitical instability, economic slowdowns, and funding withdrawals by major donors, most notably USAID in 2025. Although new contributions demonstrate stability, the projected $1.1 billion funding gap for 2026–2030 is indicative of the Partnership's constraints in meeting the full commodity needs of countries.

7. Role and added value of the Partnership in the SRH sector

The Partnership continues to deliver results in terms of increasing contraceptive availability, mobilizing domestic resources, expanding modern contraceptive method mix, and improving supply chain resilience. However, the measurement of downstream impact such as quality of care, client satisfaction and behavioural change is limited as many of these indicators are beyond the scope of the programme. Furthermore, the Partnership's monitoring framework remains heavily focused on commodity delivery and does not sufficiently capture system-level outcomes or rights-based metrics.

The Partnership's potential as a strategic influencer in global health and development is underutilized. Stakeholders note the absence of a clear and coordinated advocacy strategy to position reproductive health commodities as essential components of primary health care and universal health coverage (UHC). While UNFPA has strong technical credibility, its external communications and strategic partnerships are not fully leveraged to mobilize political will or financing for RHCS.

Conclusions

Evolution of the design

Conclusion 1 (strategic focus and value add): Phase III of the Partnership marks a strategic shift towards reinforcing government ownership, mutual accountability and sustainable financing. The emphasis on domestic financing, government ownership and partnership accountability aligns well with global development principles. However, mixed messaging through tools and indicators, as well as the rhetorical rather than substantive application of cross-cutting principles like HRBA and LNOB, among other reasons, has led to misalignment and lack of clarity about the Partnership's operational role and added value.

Conclusion 2 (country eligibility and classification): The eligibility and classification criteria developed in phase III are robust and contextually grounded. However, countries that no longer meet the criteria continue to receive support, leading to a dilution of the Partnership's financial and technical impact. The lack of a transition strategy remains a gap (which the Partnership plans to address in 2025).

Integration of humanitarian action

Conclusion 3 (humanitarian action across the continuum): The Partnership currently places limited emphasis on humanitarian action, as evidenced by the modest funding allocated to these activities. The Partnership has yet to clearly define its role within the humanitarian-development-peace (HDP) continuum. Although it has demonstrated operational relevance in crises, limited coordination with UNFPA's humanitarian structures in the absence of a joint operational framework constrains its impact in delivering context-specific SRH commodities.

Integration and coordination

Conclusion 4 (governance and agility): The governance reforms introduced in phase III, including the redefinition of the scope of the Steering Committee to strengthen its strategic leadership and oversight authority, as well as the establishment of its sub-committees, have enhanced transparency, inclusivity and stakeholder engagement. Striking the right balance between fostering a highly participatory process and the need for efficient and agile responses

remains a key challenge, particularly during crises or donor shifts (for example, COVID-19). While the restructured governance framework has improved global accountability, the meaningful participation of civil society and country-level stakeholders remains uneven.

Conclusion 5 (partnerships and country coordination): While the Partnership has made significant strides in engaging with governments, particularly through mechanisms such as the Compact and the Match Fund, its approach to collaboration with other in-country strategic and implementing partners, especially local advocates for domestic resource mobilization (DRM), remains limited. This constrains the Partnership's ability to strengthen national ownership and sustainability. In addition, the Partnership has not fully leveraged its influence to address persistent structural barriers that affect the availability and choice of SRH commodities, such as expanding the base of commodity suppliers in the Global South and ensuring effective last mile delivery within the constraints of limited HSS funding.

Conclusion 6 (adaptability and programme responsiveness): The Partnership's ability to adapt to changing contexts is a key strength, supported by tools such as the Compact, Match Fund, Bridge Fund, country risk assessments, and the SRAT. These instruments have enabled responsive programming, but maintaining up-to-date data and managing administrative burdens can strain country offices (COs). This stands in contrast with the long-term nature of HSS, which requires extended planning and identification timelines to support more strategic programming.

Financial sustainability

Conclusion 7 (securing financing commitments): The Compact and Match Fund have proven effective in catalysing national commitments to SRHR financing. However, the absence of robust accountability mechanisms, limited financial transparency and tracking gaps constrain their potential to sustain impact.

Conclusion 8 (financing tools and resource optimization): The Match Fund has proven effective in incentivizing results by linking funding to progress. Expanding the Match Fund's scope to include additional maternal health commodities may further enhance its relevance, provided safeguards are in place to avoid displacing funding for family planning.

Added value and strategic influence

Conclusion 9 (convening power and advocacy): UNFPA's strategic position enables it to serve as a powerful advocate and convener in the SRHR space. Current advocacy efforts are hindered by the absence of a coordinated global strategy, a structured measurement framework, and consistent support at the country level. As a result, activities often remain fragmented and reactive.

Conclusion 10 (funding gaps and opportunities): The slight decline in donor contributions since 2021 and the context of overall funding cuts experienced since the beginning of 2025 pose a risk to the Partnership's sustainability. While diversification efforts have expanded the donor base, and new initiatives such as the EIB initiative, complemented by bridge funding, could help fill gaps for SRH commodities in low- and middle-income countries, external factors such as geopolitical conflicts and donor funding reallocations are likely to impact the Partnership's financial security.

Conclusion 11 (resource allocation and technical capacity): Human resource constraints, especially in sustainable financing, supply chain management and advocacy, continue to limit the Partnership's implementation capacity. The transition from the Family Planning Branch to the integrated SRHR Branch, which now consists of the family planning team, the maternal and newborn health team and sexual health and HIV team, has created shared functions with the team across the Partnership and the Maternal and Newborn Health Fund (MNHF) without a commensurate increase in staffing, resulting in operational strain across all levels.

Recommendations

1. Guided by a refined theory of change, t**he Partnership should clarify and consistently communicate its strategic focus**, as a global programme for the delivery of SRH commodities and supporter of pre-defined HSS interventions.

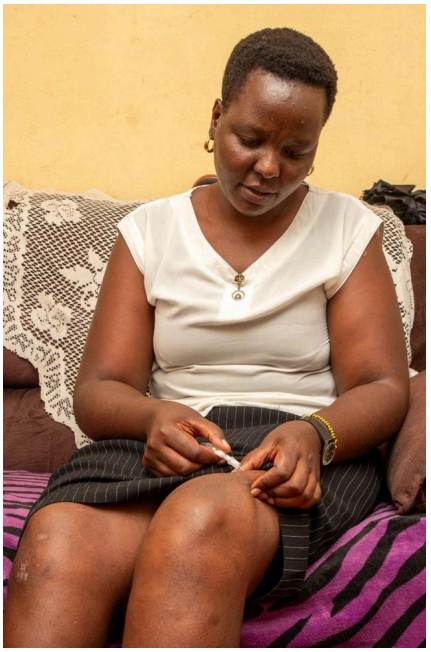
2. Going forward, the Partnership should **revise its classification of programme countries** to reflect their political, economic and health contexts and policies, and consider mapping out country transition pathways based on sustainability prospects.

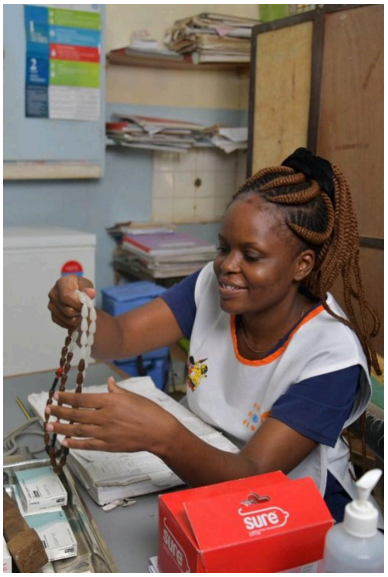
3. The Partnership, in collaboration with the Supply Chain Management Unit (SCMU) and the Humanitarian Response Division (HRD), should **identify programming aspects and contexts for strengthening its work in humanitarian contexts**, including on enhancing procurement, supply chain management and last mile delivery mechanisms, where applicable.

4. The Partnership should **intensify its resource mobilization strategy**. This includes (1) expanding and strengthening efforts to mobilize resources from a diversified base of donors and other financing partners; and (2) strategically focusing on increasing the financial ownership and investment of programme countries by strengthening domestic resource mobilization.

5. The Partnership should **optimize the functioning of the Steering Committee and sub-committee processes** to improve responsiveness and efficiency, strengthen country representation, and improve transparency and accountability in governance.

6. In each of the 54 countries, the Partnership should **strengthen its support to UNFPA COs to enhance collaboration and coordination with in-country partners** (including NGOs and CSOs) to address systemic SRH challenges more effectively. This support should also focus on aligning all UNFPA-managed funding streams with national priorities and long-term objectives, ensuring coherence across planning processes. In doing so, the Partnership can maximize the collective impact of national initiatives while enabling more strategic use of tools such as the SRAT and improving the contextual adaptation of HSS programming.





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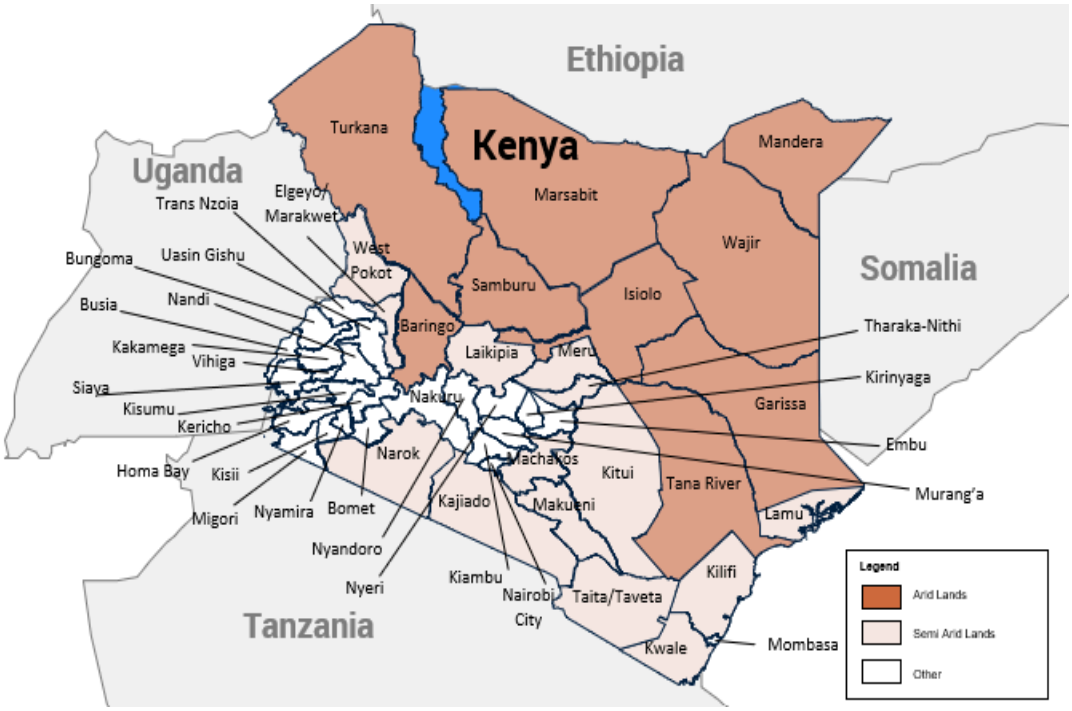
1 Introduction of the case study

Kenya is one of four countries selected for a case study under the Mid-term evaluation of the UNFPA Supplies Partnership (Partnership) (2021-2030) evaluation. The evaluation team reviewed documents and data provided by the UNFPA Kenya Country Office and conducted a country visit from 28 October to 8 November 2024. During the visit, the team met with the UNFPA Country Office leadership, team members, and key programme stakeholders, including implementing partners, beneficiaries and rights-holders (see Annex 2). These discussions enriched the evaluation with valuable context, as reflected in the findings presented below and the supporting data contained in the accompanying evaluation matrix.

2 Context

Geographic and demographic: Kenya has a population of 55 million (2022 estimate from the Kenya Demographic and Health Survey) with a life expectancy of 66 for women and 61 for men. The maternal mortality rate is 355 per 100,000 live births. Women of reproductive age (15–49 years) number approximately 14 million, with a total fertility rate (TFR) of 3.4 children, declining from 3.9 in 2014. Women residing in rural areas have higher fertility rates (3.9) than urban residents (2.8).[1]

Figure 1: Map of Kenya with neighbouring countries



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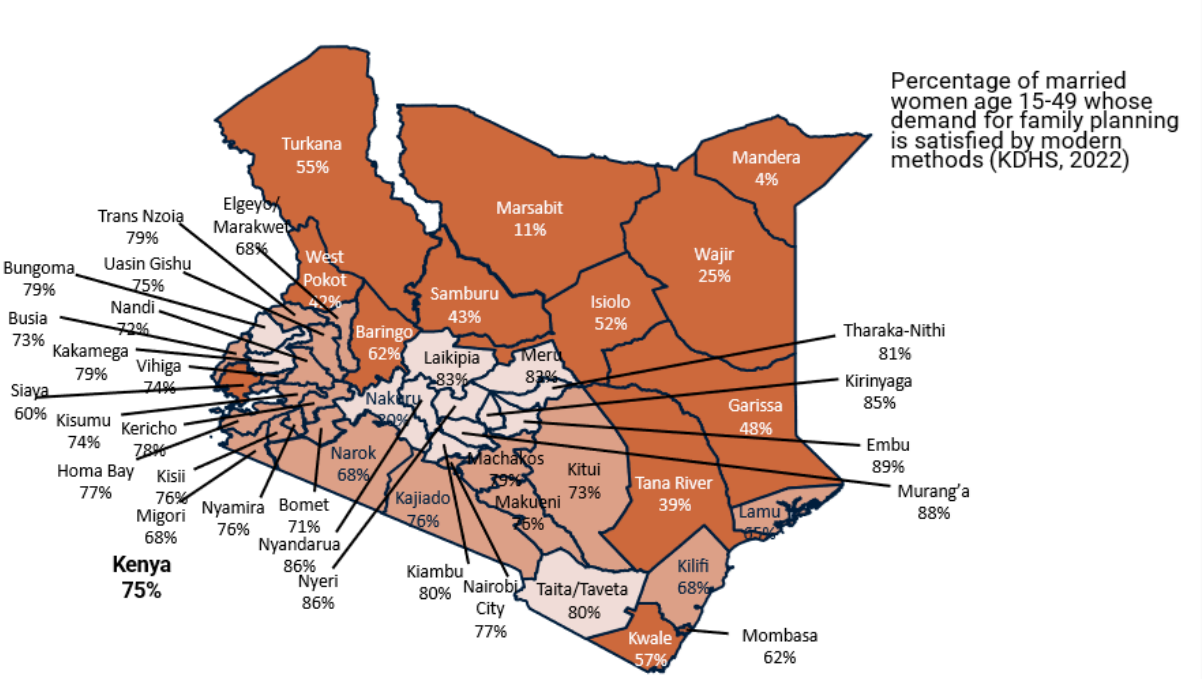
Family planning and adolescent health: About 63% of married women (15–49 years) use contraceptives, with 57% relying on modern methods such as injectables and implants. Among sexually active unmarried women, contraceptive use is 70%, with male condoms being most common. As the map below shows, significant county-level disparities exist, e.g., Embu County has an 89% contraceptive use rate, compared to 4% in Mandera County.[2] Adolescent pregnancy remains a

[1] 2022 Kenya Demographic and Health Survey. Available here
[2] PowerPoint presentation by CO Kenya Oct 28, 2024

significant challenge, with 18% of women aged 15–19 becoming pregnant,[3] with higher rates in rural and marginalized communities. The overall unmet family planning need is 14%[4] with notable disparities across counties in the access and use of modern contraceptive methods by married women where the most commonly used methods are injectables (20%), implants (19%) and contraceptive pills (8%).[5] Reasons for these disparities across counties are multi-faceted, including cultural differences, beliefs, and practices (including religion, gender inequities and literacy rates negatively affecting demand for sexual reproductive health (SRH) and family planning services); historical marginalization and relative lack of investment in some northern areas; geographical remoteness and reduced access to health workers, supplies and infrastructure; and humanitarian settings (e.g. in longstanding Garissa (Dadaab) and Turkana (Kakuma) refugee camps) where family planning is under-prioritized versus other essential needs.

Figure 2: Map of Kenya's counties and mCPR rates



Source: PowerPoint presentation by UCO Kenya 28 October 2024

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Health system and governance: The 2010 Kenyan Constitution decentralized governance, giving county governments responsibility for health service delivery across six levels,[6] while the national government develops policies. Counties, led by elected Governors and Deputy Governors, manage health budgets and implementation with the support of the County Executive Committee and elected members of the County Assembly who play a major role in the decisions on budgetary allocations.

Health financing and human resources for health (HRH): Kenya allocates 6.5% of its national budget to health.[7] Kenya's national health system is funded through government (47%), donor funds (18%), out-of-pocket payments (24%) and private sources (11%).[8] The National Health Insurance Fund

[3] 2022 Kenya Demographic and Health Survey
[4] PowerPoint presentation by CO Kenya Oct 28, 2024
[5] PowerPoint presentation by CO Kenya Oct 28, 2024
[6] L1 – Community health services composed of community health units served by community health promoters; L2 – Dispensaries; L3 - Health Centres; L4 – Sub-County Hospitals; L5 – County Referral Hospital(s); L6 – National Teaching and Referral Hospitals; these levels offer different health service packages which are defined by the Kenya Essential Package for Health (KEPH); access to health services at different levels is ideally governed by the Kenya Health Sector Referral Strategy
[7] Kenya National and Country Health Budget Analysis, FY 2020/21, pg.8
[8] CHAI Kenya Repository, Jan 12, 2025

(NHIF), restructured in 2023 into the Social Health Insurance Fund (SHIF), mandates household contributions of 2.75% of income.[9] Kenya's health workforce is regulated by eight professional bodies established by Parliament, overseeing training, licensure, and practice. Despite a health worker density of 30.14 per 10,000 population—below the threshold for Sustainable Development Goal 3 (SDG 3) progress—only 10% of trained health workers are employed, driving migration abroad.[10] While the WHO has not flagged Kenya as vulnerable to health worker emigration, the lack of tracking systems and the country's ranking as the sixth-highest African source of nurse immigrants to the United Kingdom (UK) highlight ongoing challenges.[11]

The Partnership in Kenya: Since joining the UNFPA Supplies Programme in 2007, Kenya has received support for family planning commodities, health worker training and capacity building, health system strengthening, and community outreach throughout the three implementation phases. As a lower-middle-income country, classified as a ''carry-over country'' under the Partnership, Kenya has made progress but faces significant challenges.

Seventy-five percent of the Partnership funding is allocated to commodities, which is crucial and much needed. However, the remaining 25% allocated to supply chain strengthening is minimal compared to the significant gaps that exist in this area.

The tables below, drawn from Kenya's 2022 Budget Allocation Letter, outline the planned and indicative allocations under the Partnership. In 2023, US$ 530,000 from the Transformative Action (TA) funding stream was approved and transferred to the government. These funds aimed to support supply chain strengthening, diversify funding for sustainable financing, strengthen the policy environment for commodity security and method choice, and provide seed funding to expand women's access to new and underutilized commodities. Despite these efforts, this funding remains insufficient to address the identified gaps across the country.

Table 1: Planned UNFPA Supplies Budget Allocation to Kenya 2022

Budget Category	2022 Budget Allocation
Reproductive Health Commodities	
Routine Commodities	$390,228
New and Lesser-Used Commodities	TBC - upon request
Match Fund UNFPA Contribution	Up to $1,500,000 *available from Jan 2022-Dec 2023 and requires government contribution of up to $375,000
Total	$1,890,228
Managing Accountability and Visibility	
Human Resources	TBC
Facility Surveys	TBC
Transformative Action	
Transformative Action Grant Funding	$200,000-$800,000

Source: UNFPA (2022). UNFPA Supplies Budget Allocation Letter Kenya 2022. (pages 3 and 4)

[9] Kenya | Employment Tax | The Social Health Insurance Fund (SHIF) - Oct 22, 2024
[10] Health labour market analysis for Kenya, Ministry of Health 2023
[11] Ibid

Table 2: Indicative UNFPA Supplies Budget Allocation to Kenya in 2023 and 2024

Budget Category	2023 Indicative Allocation	2024 Indicative Allocation
Reproductive Health Commodities		
Routine Commodities	$390,228	$390,228
New and Lesser-Used Commodities	TBC - upon request	TBC - upon request
Match Fund UNFPA Contribution	Up to $1,500,000 *available from Jan 2022-Dec 2023 and requires government contribution of up to $375,000	TBC
Domestic Fund Contribution Requirement from Government	$39,023	$58,534
Managing Accountability and Visibility		
Human Resources	TBC	TBC
Facility Surveys	TBC	TBC
Transformative Action		
Transformative Action Grant Funding	$200,000-$800,000	$200,000-$800,000

Source: UNFPA (2022). UNFPA Supplies Budget Allocation Letter Kenya 2022. (pages 3 and 4)

Additionally, the 2023 Allocation Letter specified $1.7 million for routine reproductive health and family planning commodities. While Match Funding is available, the country's constrained fiscal space has prevented the government from meeting the eligibility requirements to access these funds. Key partners— Foreign, Commonwealth and Development Office UK (FCDO), USAID, and the Bill & Melinda Gates Foundation (BMGF)—are reducing or ending family planning funding commitments between 2025 and 2026. This creates uncertainty about future financing, exacerbated by the growing demand that exceeds the UNFPA initial targets. For example, the number of modern contraceptive users in Kenya has consistently surpassed projections. Efforts to address gaps include strengthening supply chains, training health workers, and expanding access to remote and underserved populations. However, with donor funding reductions, the family planning landscape faces a looming crisis.

3 Case study findings

The Kenya case study for the Mid-term evaluation of the Partnership assessed the programme's design, effectiveness, and challenges through six key evaluation questions as follows. Operating under four strategic pillars—Availability and Choice, Strengthened Supply Chains, Increased Government Commitment, and Operational Effectiveness and Efficiency—the Partnership integrates human rights-based approaches (HRBA), gender-transformative actions, and principles of leaving no one behind (LNOB). Kenya, categorized as a "carry-over country," experiences both progress and significant challenges within this framework.

EVALUATION QUESTION 1: To what extent can the design of the Partnership contribute to addressing the needs of women globally and the current barriers to accessing a choice of quality reproductive and maternal health commodities in line with their needs and preferences, including in humanitarian situations?

Strengths and weaknesses of the Partnership design: The Partnership design integrates key principles such as: broad partnerships, country leadership, sustainability, health system strengthening (HSS), and advocacy. Its structural features, including the Country Compact and the Steering Committee, help foster accountability and collaboration. The Partnership's allocation formula prioritizes 75% of funds for commodities, ensuring the availability of contraceptives, with the remaining 25% dedicated to HSS and Matching Assistance for Voluntary family planning (MAV), focusing on systemic improvements and equitable access. In Kenya, the Compact agreement represents a significant step toward securing government commitment to family planning funding. However, challenges include limited government compliance with financial commitments to date, perceived misalignment with Kenya's existing memorandum of understanding (MoU) with key family planning donors, insufficient consultation (as perceived by some) during the Compact's 9-month process toward signing, and apparent duplication or unilateral nature of the Country Compact.

As Kenya had an existing (and still active) MoU (2019-2026) with the key family planning donors (USAID, FCDO, BMGF), the Government (and some partners) are critical about the lack of alignment of the Compact with this MoU and the apparent duplication or unilateral (by UNFPA) nature of the Compact (and some expressed a preference for the family planning donors/partners to pool their funding support and work more closely together with the new Government to build upon what has been done previously in family planning in Kenya - e.g. by 2022, Kenya was reportedly procuring 60% of their own family planning supplies), without reverting to a "partner-led approach").[12] Additionally, the single-year budget cycle creates planning difficulties, as UNFPA disbursements conflict with Kenya's fiscal calendar, limiting the ability of implementing partners to execute long-term strategies effectively. Implementing partners noted that it is good to have innovative mechanisms like the Compact and the Match Fund to secure government commitment in writing, while there is still work to do to secure the committed funds in these challenging financial times in Kenya (with the government reportedly using 80% of its funds to service its debts).[13]

Capacity to adapt to different contexts: The Partnership demonstrates a degree of adaptability, tailoring interventions to address the needs of diverse contexts such as humanitarian settings and underserved regions. For example, in Kenya, it supports the arid and semi-arid lands (ASAL) and refugee camps, ensuring access to SRH commodities and training for health workers. Humanitarian efforts, such as the provision of SRH kits and capacity building for emergency responders, align with the commitment to marginalized populations. However, Kenya's classification as a carry-over country limits the Partnership's ability to address regional disparities effectively as overall the classification does not reflect the ongoing reality of large disparities by county, thereby creating the idea that "the country looks adequate but hides problems in the worst areas" and places an additional burden on the country through "an expected 10% contribution going up each year".[14] The large range in contraceptive prevalence rates (CPR) and decentralized nature of the Kenya Government underscore the need for more nuanced, subnational adaptations (and closer work with county and sub-county leadership). While tools like the integrated logistics management information system (iLMIS) and partnerships with community-based organizations have shown promise , there remain many local challenges.

Adequacy of the approach for grouping and classifying countries: The Partnership's grouping and classification system, based primarily on aggregate economic indicators and national-level SRH metrics, enables targeted resource allocation. However, this approach often overlooks significant internal disparities within the country, where national averages mask stark regional inequalities. Kenya's designation as a carry-over country does not fully reflect the country's challenges, including financial austerity, unmet family planning needs in remote areas, and gaps in service delivery. The "tyranny of averages" diminishes the visibility of low CPR regions, limiting the impact of interventions. Furthermore, the classification system does not allow for consideration of the decentralised nature of health governance in Kenya, the varied subnational contexts and socio-economic conditions, aspects that affect the programme's ability to target resources effectively and equitably.

Relevance of current funding streams (Supplies, HSS, MAV): The Partnership's funding allocation of 75% for supplies, 15% for HSS, and 10% for MAV reflects a strong focus on commodity security, while under-emphasizing the systemic barriers to access. The commodities funding stream has ensured the availability of modern contraceptives, supporting women's access in underserved and humanitarian settings. However, the remaining 25% is insufficient to address critical gaps, such as strengthening supply chains, improving health worker capacity, and reaching marginalized populations. For instance, the $530,000 allocated to Kenya in 2023 for HSS and policy enhancements is inadequate given the country's vast needs (e.g. ongoing need for advocacy at various leadership levels to mobilize Government support; need to expand training and LMIS access for health workers and community health promoters (CHPs) in more counties and sub-counties (and inclusion of LMIS in pre-service training for health care workers (HCWs); need for more media outreach to inform and educate; need to expand the reach and volume of commodities including dignity kits to meet growing needs; need to increase partnerships with private sector entities playing a key role in the health sector;

[12] FP2030 KII
[13] CHAI KII
[14] UNFPA staff

the need to increase data reviews/support for counties and sub-counties to improve data for supply chain management (SCM); and others (as recommended by respondents to this mid-term evaluation). Moreover, Kenya's inability to meet its Compact funding commitments has rendered it ineligible for $1.5 million in potential MAV match funding, exacerbating financial constraints. In addition, the lack of emphasis on multi-year budgeting and expanded range of diversified financing mechanisms affects predictability and sustainability.

Cross-cutting principles: The Partnership emphasizes equity, human rights, and sustainability, aligning with global commitments to LNOB. The Partnership has targeted underserved groups, including adolescents, refugees, and women in marginalized areas, through partnerships with organizations like Polycom Girls and This Ability Trust. These initiatives address key issues such as gender-based violence (GBV), adolescent health, and access for women with disabilities. Humanitarian settings also benefit from Partnership support, with SRH kits and capacity-building efforts integrated into the Minimum Initial Service Package (MISP). However, gender and youth perspectives are not yet adequately integrated into programme planning and implementation.

Private sector collaboration has been a critical component of the Partnership strategy in Kenya. Partners such as DKT International and PSI Kenya have helped expand access to SRH/family planning services, particularly for youth and women who prefer private facilities due to stigma, privacy concerns, and better service quality. Efforts to adopt a Total Market Approach (TMA) have further strengthened the availability of affordable contraceptives through public and private channels. There is not yet adequate coordination between sectors of the Government, such as health and education, to support enhanced access to SRH information and services, especially for adolescent girls.

EVALUATION QUESTION 2: To what extent is the Partnership effective at increasing availability and choice of reproductive health and family planning commodities for all women who want and need them, including marginalized groups and those in humanitarian situations, through Partnership strengths in global forecasting, procurement, quality assurance, and delivery?

Availability and choice: The Partnership has significantly improved the availability and choice of family planning commodities by leveraging UNFPA global purchasing power to source high-quality products at competitive prices.[15] The procurement is entirely handled by UNFPA, while the Kenya Medical Supplies Authority (KEMSA)[16] handles distribution and warehousing. The introduction of new and lesser-used products (NLUs) under the Partnership – such as the self-injectable subcutaneous Depo (DMPA-SC), hormonal intra-uterine devices (IUDs), and permanent methods (including vasectomy and tubal ligation)– has expanded the range of contraceptive options available.[17] Collaboration with the Ministry of Health (MoH) has facilitated efficient procurement and distribution of contraceptives, including injectables, implants, and condoms. An analysis of the UNFPA 2021-2024 Commodities Spreadsheet[18] reveals that commodity prices did not change much (or at all) year to year; and the largest volumes and costs were for Levonogestrel, MPA 150mg, and LNG 5-year implants.

Despite these successes, challenges persist. Supply chain disruptions, such as delays from suppliers and misalignment between UNFPA and Government of Kenya fiscal years,[19] have led to periodic stock-outs of key products, including DMPA-SC. Stock-outs hinder the consistent availability of commodities in public health facilities, limiting access for beneficiaries. Additionally, uptake of some products, such as IUDs and permanent methods, remains low due to inadequate health worker training,

[15] ICRH KII and UNFPA country office in-brief of MTE team October 28, 2024; some inaccuracies were noted in the spreadsheet

[16] KEMSA is an agent of the Ministry of Health, responsible for procurement, warehousing, and distribution of Health Products and Technologies (HPTs) for the public sector

[17] KEMSA KII

[18] Kenya 2021-2024 UNFPA Commodities (Excel file from UNFPA Country Office)

[19] Kenya's fiscal year runs from July 1st of the current calendar year to June 30th of the following year.

misconceptions,[20] and infrastructure challenges[21]. These obstacles illustrate the multi-faceted reasons for supply and demand challenges impacting access to a broad range of family planning commodities.

Additionally, access to SRH/family planning services for young women is hindered by legal constraints such as parental consent rules limiting access to SRH for adolescents, opposition from conservative factions, and discrepancies between the more progressive Constitution and applied laws (the penal code opposes adolescent SRH), which create barriers for policymakers, as well as for health workers.[22] The Partnership has leveraged the credibility of UNFPA to convene a multisector coalition[23] advocating for youth access to SRH/family planning services, addressing opposition and promoting evidence-based policymaking. While urban youth often find youth-friendly spaces, rural youth face greater challenges in access, compounded by misinformation from the education system,[24] further contributing to high rates of teen pregnancies and other vulnerabilities including risk of HIV, sexually transmitted infections (STIs), school drop-out, unsafe abortion, etc.

Support for Family PLanning forecasting, supply planning and procurement: The Partnership has supported Kenya's efforts to enhance forecasting and procurement through collaboration with national and subnational stakeholders, including the MoH, KEMSA, and various technical partners (RHNK, PSI-K, CHAI, MS-K, ICRH-K). Annual national forecasting exercises, supported by tools like the Reality Check® demographic forecasting tool and others,[25] ensure that commodity needs are projected accurately. The development of the National Supply Plan, managed by the UNFPA Supply Chain Management Unit (SCMU), helps maintain adequate stock levels and minimizes supply disruptions.[26]

Kenya's participation in the Global Family Planning Visibility Analytics Network (GFP VAN) further enhances quantification and forecasting to improve supply chain visibility and data-driven decision-making, thereby reducing risk of stock-outs and overstocking. The involvement of partners like In Supply and PSI-K in the Consensus Planning Group (CPG) has strengthened coordination and responsiveness in managing commodity stocks as CPG "combines both the hands-on skills required to address stockout emergencies with the expertise needed to prevent disruption by aligning orders before they are ever shipped" (according to the RHS coalition web site (https://www.rhsupplies.org/gfpvan/collaboration-planning.html). They, along with UNFPA and KEMSA, also play a crucial role in stock management and security monitoring through technical working groups and order management teams, ensuring coordinated distribution and addressing supply imbalances within counties. However, limitations remain, including inconsistencies in data quality and alignment of procurement timelines with funding cycles. These gaps hinder the Programme's ability to ensure reliable access to SRH/family planning commodities.

Expanding method choice: The Partnership support for expanding method choice has enabled Kenya to diversify its family planning offerings, particularly for underserved populations including adolescents, young mothers and commercial sex workers. UNFPA has been working to bring on board other partners (e.g. private sector, manufacturers, distributors) to complement the efforts of government and non-governmental organizations (NGOs), and to develop the demand side (e.g., through the TMA ensuring free products for those most in need (those underserved and vulnerable groups) in addition to

[20] Misconceptions about IUDs include fear that it might travel to other parts of the body, fear it will cause permanent infertility, fear of pain and bleeding

[21] E.g. lack of proper equipment, insertion tools, space, training

[22]There is now a strict policy in Kenya, brought in by the new govt in 2022, led by a new MoH official with strict religious values. Whereas the national ASRH policy was very progressive, the head of RMNCAH at MoH forced a revision of this policy. Now, service providers are reportedly afraid to serve adolescents. The policy includes a parental consent rule stating that those 18 and younger need parental consent to obtain SRH/family planning services. (NAYA KII)

[23]Reproductive Health Network Kenya (RHNK) KII

[24] Narok sub-county focus group discussion (FGD) with women beneficiaries - the women noted that the education system was also a barrier to adolescents accessing SRH because of schools spreading disinformation regarding family planning methods being potentially harmful to adolescents. This was cited as one of the contributors to high rates of teen pregnancies in their communities.

[25] KDHS 2022 data, Track 20 family planning estimation tool (FPET), Population Services (PS) Kenya TRaC 2016 and Performance Monitoring for Action (PMA) surveys, Kenya National Bureau of Statistics (KNBS) 2019 Census, as well as logistics data and service statistics from KHIS.

[26] using the "PipeLine®" tool, planning for 16-22 months of stock (MOS) to be held in the country at any given time

reasonable pricing for others and engaging not only the media but religious and traditional leaders in advocacy efforts), for family planning commodities to expand availability and choice. Innovations like the introduction of self-injectable contraception such as DMPA-SC have empowered women to manage their reproductive health autonomously. Social enterprise models implemented by partners, such as PSI-K, have complemented public sector efforts, ensuring that family planning products remain available even during public sector shortages. These private sector contributions align with the TMA advocated by the Partnership, ensuring that the very poor get products for free, while others can buy them at a reasonable price in non-government outlets which is seen as a "game changer".[27]

Key opportunities for expanding method choice include leveraging partnerships to strengthen community outreach and demand generation, especially in rural and marginalized areas. However, challenges persist, including cultural resistance, inadequate health worker training for newer methods, and logistical barriers in remote regions. Enhanced collaboration between public and private sectors and investments in training and infrastructure are critical to overcoming these limitations.

Humanitarian settings: Kenya has a large population of refugees (more than 500,000) from Somalia, South Sudan, DRC, and Ethiopia, with most of these displaced persons (many for decades) living in the two largest refugee camps.[28] The Partnership has played a pivotal role in addressing SRH/family planning needs in humanitarian settings, including these refugee camps (e.g. Dadaab - established in 1991 - in Garissa County to the east, and - the largest, operating since 1992 - Kakuma in northwestern Turkana County), Kenya's ASAL, and disaster-affected areas (e.g. flood zones). Through partnerships with organizations like the Kenya Red Cross Society, the Partnership provides essential SRH kits and supports the implementation of the MISP for reproductive health. Capacity-building initiatives for health workers in these settings are supported by the Partnership along with the provision of kits to the facilities. In Kakuma and Dadaab refugee camps, for instance, the Kenya Red Cross Society (with funding under the humanitarian line of the UNFPA budget) conducts training while UNFPA carries out procurement activities.[29] This facilitates the effective delivery of SRH services, including family planning, in these humanitarian settings. Additionally, the Partnership's support to the integrated family planning iLMIS has helped ensure that there is monitoring of kits supplied for humanitarian settings including consumption data to help inform the forecasting and supplying of stocks.[30]

Despite these efforts, access to SRH/family planning commodities is often hindered by logistical challenges, security concerns, multi-agency documentation and approval delays, and inadequate infrastructure. While the linkages between humanitarian programs and the Partnership — such as the inclusion of family planning commodities in interagency reproductive health kits — enhance service integration, they remain insufficient to meet the growing needs in these contexts, which require more collaboration with local organizations and more funding.

EVALUATION QUESTION 3: To what extent is the Partnership effective at ensuring that reproductive health commodities reach the "last mile" and promote harmonization and integration of supply chain systems in countries for all women who want and need them, including marginalized groups and those in humanitarian situations?

Identification of key gaps in SCM: The Partnership has been instrumental in identifying and addressing critical gaps in Kenya's SCM for SRH commodities. Through Last Mile Assurance (LMA) assessments conducted in 12 counties and 137 health facilities since 2021, significant issues such as stock-outs, poor forecasting, storage inadequacies, and human resources challenges have been identified.[31] In addition, a 2022 spot check report[32] found inadequate traceability of products (bin

[27] ICRH KII

[28] Kenya 2021 Kenyan Economic Survey - EGRISS (Expert Group on Refugee, IDP, and Statelessness Statistics) https://egrisstats.org/implementation/country-case-studies/kenya/#:~:text=Many%20refugees%20in%20Kenya%20have,the%20northwest%2C%20and%20in%20Nairobi.

[29] Red Cross KII

[30] UNFPA (2023). Kenya Country Narrative Report 2022. (pg2)

[31] KEMSA KII and LMA Spot Check report - May 2022

[32] Last Mile Assurance Assessment report, 2023 - Kwale & Kilifi Counties Dissemination on LMA Spot Check Findings, and FP Supply Chain Management Orientation. April 2023 (pgs6, 13, 15)

cards/records gaps), stock-outs, storage problems and expiries, along with missing/lost commodities and falsified delivery slips. Action plans developed from these assessments have enabled targeted interventions, including training, mentoring, and redistribution of supplies.

UNFPA collaborates with and funds partners like KEMSA, MOH, MS-Kenya, Counties and ICRH--Kenya to address gaps identified through LMA assessments by training health facility workers on commodity management, supporting stock redistribution, and rationalizing supplies across counties. It was noted by key informants that there is an improvement in service delivery because of the enhanced capacities that resulted from the investments of UNFPA, including more counties trained on the iLMIS, helping to build efficiency in the supply chain. [33]

Implementation of the Partnership-designed Sustainability Readiness Assessment Tool (SRAT) (produced annually, following the LMAs) has further helped counties to identify weaknesses in their SRH/family planning programme management and supply chain operations (such as recurring stock-outs, data quality challenges, and others), providing suggested priority areas for improvement to build a more sustainable supply of commodities. However, key limitations persist, including: the inability to scale LMA assessments across all counties, persistent stock-outs, data quality issues at health facilities, traceability gaps, and logistical challenges in reaching remote areas.

Support to SCM Systems: The Partnership has significantly supported the development and implementation of integrated supply chain systems in Kenya through support to systems within KEMSA and in the Counties. The iLMIS, largely funded by the Partnership with the support of other donors (InSupply, CHAI, MSI and others), has been a "game-changer" (according to numerous respondents) in improving data visibility and reducing inefficiencies. By 2023, 40 counties had adopted the iLMIS, reducing order turnaround time (OTAT) from 20 to 7 days and improving delivery timelines.[34] UNFPA through the partnership has also supported the capacity development of the health workers who use the iLMIS. Additional catalytic support from UNFPA for improved data visibility and SCM has included the digitization of the National Supply Chain Management Training Package and the Family Planning Commodities Tax Exemption Tool, as well as the introduction of the Visibility Analytical Network (VAN) and the development of tools like the Electronic Proof of Delivery (ePOD) app, which provides real-time delivery data.

Despite these advancements, limitations remain. Only 35 of Kenya's 47 counties have received full training on the iLMIS,[35] hindering consistent implementation nationwide. Data quality issues, particularly at lower-level facilities (which largely use manual/paper-based record keeping), continue to affect accurate forecasting and stock management. Moreover, trust issues with KEMSA, due to past mismanagement incidents, limit its role in procurement, despite its improved capabilities in warehousing and distribution. There are remaining needs for more training, data management improvements, and ensuring visibility and transparency within KEMSA and the supply chain.

Reaching the last mile: Reaching the last mile has been a core focus of the Partnership, with significant progress achieved in ensuring SRH commodities reach underserved and remote populations. Innovations such as the ePOD app, developed through a UNFPA-supported public-private partnership between Coca-Cola Beverage Africa and KEMSA, have enhanced efficiency and traceability in deliveries to health facilities. Redistribution of commodities between facilities, supported by partners like MS-Kenya, CHAI, In Supply, and PSI-Kenya, has been critical in addressing local stock imbalances. Humanitarian efforts, including partnerships with the Kenya Red Cross Society, ensure the availability of SRH kits in disaster-affected areas and refugee camps, leveraging specialized logistics capabilities to navigate challenging terrains.

However, as previously stated, challenges persist in ensuring last-mile delivery and constant supply in remote areas, including logistical barriers (communications, roads, transport suited for rough terrain, electricity) to reaching remote regions, frequent stock-outs and inadequate inventory management or storage conditions, and regulatory delays in clearing imported commodities. For instance, the Kenya

[33] PSI-Kenya KII
[34] UNFPA Country Office in-briefing session October 28
[35] KEMSA KII

Red Cross has faced issues with lengthy clearance processes due to stringent documentation and shelf-life requirements (for each item within the SRH/family planning kits). Inconsistent availability of high-demand products like the DMPA-SC self-injectable further highlights the need for improved supply chain coordination. Implementing partners are requesting that donors including UNFPA plan earlier (and prepare documentation) for planned commodity imports in Kenya, consider options to preposition supplies for some areas, and make better use of digital tools for commodity tracking and distribution.

EVALUATION QUESTION 4: To what extent is the Partnership contributing to strengthening an enabling environment where governments take up the responsibility of providing choice to quality reproductive health commodities to those who want or need it?

Increasing and diversifying government financial contributions: UNFPA and its partners have engaged in extensive advocacy to secure government financial commitments for SRH/family planning programmes in Kenya. Efforts led to the signing and re-signing of the Partnership Country Compact with the Government of Kenya in 2023 and 2024, respectively, involving the key stakeholders UNFPA, the MoH, and the Ministry of Finance (Treasury), with support and inputs from many other partners. However, the Government has not met its funding commitments, with family planning funding often deprioritized within MoH budget allocations. This limits eligibility for Match Fund contributions, as compliance with co-funding requirements is necessary to access these resources. As family planning funding is seen as less urgent within the MoH (and reportedly is the first thing to be cut), given the budget austerity measures in place, advocacy by UNFPA and other partners is an ongoing task.

Advocacy and data generation: Partnership collaboration with partners such as the National Council for Population and Development (NCPD), FCDO, USAID, ICRH-K, PSI-K, CHAI and FP2030 have included initiatives such as policy reviews, forecasting exercises, and the development of business cases highlighting the role of family planning in economic development. In addition, SMART advocacy,[36] utilizing tailored, strategic, and time-bound approaches, has been a cornerstone of UNFPA efforts with its partners to influence policy and mobilize political commitments for SRH/family planning. Despite these efforts, funding by the Government of Kenya remains inconsistent, hindered by fiscal constraints, austerity measures, and low prioritization within the MoH and the Treasury.

Sustainability Readiness Assessment Tool (SRAT): As noted above, the SRAT has been instrumental in identifying gaps in Kenya's capacity to sustain SRH/family planning programming. Undertaken annually in collaboration with partners and informed by LMA assessments and other key National documents, SRAT evaluations highlight key areas for improvement. The 2022 national-level SRAT assessment scored Kenya 3.33 out of 5, with critical gaps in the humanitarian element (2.0) and greatest strength in service provision capacity (4.17).[37] However, the tool does not address upstream issues such as inconsistent government funding flows, which directly affect the sustainability of commodity supplies.[38]

Financing Tools: The Match Fund is a valuable financing tool designed to incentivize government co-funding for SRH/family planning programming through additional funding, but the impact in Kenya is limited due to the government's inability to meet co-funding commitments (leaving Kenya ineligible to receive Match Funding to date). Some respondents noted that a pooled funding mechanism, similar to models in other countries like Ethiopia, could harmonize donor contributions, improve trust with the Treasury, and simplify resource mobilization. However, fiscal constraints and the lack of integration between donor and government financial systems remain significant barriers to sustainability.[39]

[36] SMART advocacy is known as a strategic approach using "SMART" criteria: Specific, Measurable, Achievable, Relevant, and Time-bound - focusing on targeted actions to engage with and influence decision-makers directly, with short-term goals and tailored messages to persuade them to act. Smart Advocacy Guide (www.smartadvocacy.org) link.
[37] 2022 Kenya SRAT December
[38] InSupply KII
[39] MoH SRH technical team KII; NCPD KII

EVALUATION QUESTION 5: To what extent are the governance mechanisms, processes, and structures of the Partnership efficient at supporting the achievement of other strategic objectives and to what extent is this supported institutionally by UNFPA?

Strengths and weaknesses of the governance structure: The global governance structure of the Partnership, led by the Steering Committee and sub-committees, is viewed positively but would benefit from greater country representation and inclusion of government stakeholders such as the MoF/Treasury. The rotating civil society organization (CSO) seat, represented by Kenya this past year, highlighted the lack of a platform for gathering feedback from other countries, leading to a unilateral voice (the voice of the one country represented) at global meetings. Within Kenya, governance is coordinated through the MoH, NCPD, NOMT, and COMT/SCOMT committees, with notable improvements in partner coordination. However, irregular meetings due to funding constraints and frequent policy turnover from election cycles pose challenges, compounded by the autonomy of counties, only four of which have family planning budget lines. [40]

Coordination and synergies across actors: Coordination among partners in Kenya has improved significantly, with clear synergies between key actors like the MoH, NCPD, and KEMSA, despite varying levels of commitment. Improved coordination and synergies have been developed through technical working groups (TWGs), the national, County and Sub-County order management teams, joint advocacy efforts, and activities conducted between and among partners at national, county, sub-county, and health facility levels. The Partnership design (and breadth of partners and collaborators) is seen by key informants as helping to reduce barriers to SRH/family planning through synergies for smart advocacy, provision of quality commodities, training and capacity building, support for technical innovations including the iLMIS, policy and guidelines revision and development, outreach and access for communities and marginalized groups, and integration of services across sectors (although the latter could improve, if there were better coordination between the MoH and Education, for example, to enhance access for girls). Challenges include different levels of commitment among the government partners (MoH, KEMSA, NCPD, Human Rights Commission) and uncertainty about future funding from major donors, some of whom are significantly cutting their SRH/family planning programmes.

Adequacy of MAV funds and human resources: Human resource capacity within UNFPA Country Office is stretched, lacking senior-level supply chain specialists and relying heavily on the Family planning/RHCS specialist. While logistical support is provided by Programme Assistants and clerks, both the Country Office and the global SCMU face an "acute lack of human resources across most SCM teams"[41] and a lack of skills mix availability, impacting programme efficiency. Recruitment efforts are underway, but current resource constraints limit the ability to fully implement the programme and meet growing demands.

Linkages between pillars and strategic objectives: The Partnership demonstrates strong integration between the pillars of Availability and Choice and Strengthened Supply Chains, working effectively to achieve country objectives. However, synergies with the pillars of Increased Government Commitment and Operational Efficiency remain less clear, underscoring the need for stronger alignment across all four pillars. Despite these gaps, the programme operates as a cohesive system, striving to address Kenya's SRH/family planning challenges through coordinated, multi-stakeholder efforts.

EVALUATION QUESTION 6: To what extent is the Partnership aligned with, complementing, and filling gaps of other UNFPA initiatives as well as other global initiatives aimed at strengthening access and use of quality reproductive health commodities, while also considering the Nexus approach?

Alignment with the Country Programme and UNFPA initiatives: The Partnership is well-integrated within the UNFPA Country Programme, cutting across its five outputs, including regulation, quality SRH, GBV, adolescent SRH, and evidence-based programming. Humanitarian support aligns with all five

[40] MoH SRH tech team KII

[41] UNFPA Supply Chain Management Unit Strategy - An organizational strategy for 2024-2029 (pg11)

outputs, reflecting the UNFPA holistic approach. Stakeholders generally perceive the Partnership as indistinguishable from the broader UNFPA mission, highlighting its complementarity with and integration in the Country Programme. At the national level, the Partnership is most visible, working closely with policymakers to ensure alignment with government strategies, fostering ownership and sustainability. However, at the sub-national level, the distinct role of the Partnership is less clear, with county and sub-county-level stakeholders viewing it as part of a collective effort to provide products from multiple programmes. Partnership implementing partners working at county level provide vital information to county governments and help to build capacity, while at the health facility level, the Partnership is seamlessly integrated with other UNFPA and partner initiatives.

UNFPA has taken proactive measures to strengthen coordination and avoid duplication through dynamic stakeholder mapping and regular gap analyses. These processes have identified partnership gaps, such as the previous lack of focus on permanent contraceptive methods, prompting the addition of MS-Kenya as an implementing partner. Quarterly meetings with key partners and government representatives, led by UNFPA, provide a valuable platform for monitoring progress, resolving challenges, and fostering knowledge exchange. These efforts have enhanced the alignment of the Partnership with other UNFPA initiatives, including advocacy, youth engagement, training, SCM, and demand creation. Overall, the Partnership is well-aligned with broader efforts of UNFPA, with room to enhance awareness and differentiation of its specific contributions at the county level.

Added value and complementarity with Global Health Initiatives (GHI): The Partnership's catalytic role enhances SRH/family planning access by coordinating and complementing the work of partners such as MSI-Kenya, CHAI, and the Kenya Red Cross. As mentioned above UNFPA leadership in stakeholder mapping, gap analysis, and resource allocation minimizes duplication and ensures efficiency. The Partnership has introduced innovative financing mechanisms like the Adolescent Sexual and Reproductive Health Development Impact Bond (DIB)[42] and tools such as the Visibility Analytical Network (VAN) to enhance supply chain visibility. However, funding uncertainties from key donors post-2025 threaten the sustainability of these efforts, underscoring the importance of continued leadership and strategic advocacy from UNFPA.

Complementarity with demand generation activities: The Partnership complements demand generation efforts through partnerships with organizations like CHAI, Marie Stopes, Counties, ICRH-K and This Ability Trust, focusing on new product rollouts, training, and advocacy. However, persistent challenges such as stockouts, inadequate supplies, and limited training, undermine the ability to meet growing demand and provide true method choice for clients. Health workers often struggle to align demand generation with consistent product availability, creating gaps in service delivery and reduced client satisfaction. Improved training, SCM, and resource allocation are critical to addressing these issues.

Humanitarian-Development Nexus: The Partnership effectively integrates humanitarian and development efforts, addressing both immediate needs and long-term goals in marginalized and remote areas. This is done in part through the provision of commodities, capacity building, advocacy, and supply chain support to enhance access for these marginalised populations, working through partners like the Kenya Red Cross Society, This Ability Trust, MSI-Kenya, and the Kenya Human Rights Commission. The Partnership collaborates with partners to address emergency needs stemming from crises such as severe flooding and to reach marginalized populations in remote and underserved areas, including the ASAL regions. These efforts prioritize the principles of LNOB and HRBA, focusing on vulnerable groups such as persons with disabilities, young girls, refugees (70% of whom are female), and other marginalized communities.

Funding for humanitarian efforts is drawn from a combination of sources, including the Partnership, UNFPA Humanitarian Response Division (HRD), and other donors, reflecting a collaborative approach

[42] To "fund the delivery of high-quality, adolescent and youth-friendly sexual and reproductive health services, including HIV testing and treatment, to adolescent girls aged 15-19."
https://www.unfpa.org/updates/launch-first-adolescent-sexual-and-reproductive-health-development-impact-bond-kenya#:~:text=This%20innovative%20Bond%20will%20fund,new%20HIV%20infections%20among%20adolescents

to resource mobilization. By aligning its humanitarian efforts with long-term development goals, the Partnership ensures that immediate needs are met while laying the foundation for sustainable progress.

4 Conclusions

The Partnership has driven significant progress in Kenya by enhancing availability and access to SRH and family planning commodities, improving SCM, reducing unmet need, and supporting vulnerable populations. Through strong and diverse partnerships and innovative tools like the iLMIS and ePOD, the Partnership has strengthened forecasting, procurement, and delivery systems. New and lesser used methods have also been introduced with some success. The Partnership has also introduced innovations in SCM and improved visibility of commodities, and trained health workers and supply chain personnel at national and sub-national levels. However, challenges such as funding gaps, fiscal misalignment, legal constraints, supply chain disruptions, and barriers in humanitarian settings persist. The Supplies Partnership in Kenya operates currently within a challenging fiscal environment of budget austerity, with co-financing commitments not being met by the Government, and with mixed levels of support for various SRH/family planning initiatives and provision of commodities.

Advocacy and policy engagement have been key to the Partnership's success, fostering government participation through mechanisms like the Country Compact and the SRAT tool. Nevertheless, fiscal constraints, fragmented donor mechanisms, reductions in donor/partner funding and programmes, and inadequate government funding threaten sustainability. By addressing these limitations and building on its innovative and collaborative approaches, the Partnership remains a vital and well-aligned component of UNFPA Country Programme, contributing significantly to Kenya's SRH and family planning landscape.

Annexes

Annex 1: Evaluation matrix

EVALUATION QUESTION 1: To what extent can the **design of the Partnership contribute to addressing the needs** of women globally and the current barriers to accessing a choice of quality reproductive and maternal health commodities in line with their needs and preferences, including in humanitarian situations?					
CRITERIA	Relevance	**AREA OF INTEREST**	Design of the Partnership	**LINKAGES TO THE THEORY OF CHANGE**	Linked to the area of inputs and resources included at the bottom of the reconstructed theory of change
RATIONALE	The purpose of this evaluation question is to determine the **significance and appropriateness of the Partnership design**. The analysis is focused on assessing the relevance of the design of the Partnership, and the extent to which it contributes and maximize the Partnership capacity to address its expected goals. The evaluation question looks at whether the Partnership model remains responsive and relevant to evolving demands within its operating environment (soundness of the Partnership design). Addressing this question is critical given that the Partnership design in its Phase III presents a major departure point from prior phases, notably due to its intense focus on sustainable financing. The evaluation question will appraise whether the new approach and strategy—including its emphasis on sustainable financing, structure as a partnership, and custom-tailored approach for partner countries with special attention to the LMA are relevant and aligned with diverse contexts—including regional variations, developmental stages, humanitarian needs, and fragile states. The criteria used for grouping and supporting countries into categories and the various modes of engagement that have been defined will also be evaluated for suitability. Moreover, the question will address whether the design of the existing funding streams, such as HSS, supplies, bridge fund, and match fund, are pertinent. Another significant consideration of this question is how well the Partnership adheres to human rights principles, gender equality, and LNOB. commitments. Meanwhile, the extent to which the design is being effectively implemented is considered in subsequent question (evaluation question 2).				

Assumption 1.1 The Partnership approach, with a focus on sustainable financing and framed as a partnership, includes **relevant measures to ensure the effective** adaptation to different and changing contexts with a view to maximizing contribution towards expected goals.
Indicators **1.1.1** Extent to which the Partnership establishes detailed responsibilities and commitments of all stakeholders.

Assumption 1.1 The Partnership approach, with a focus on sustainable financing and framed as a partnership, includes **relevant measures to ensure the effective** adaptation to different and changing contexts with a view to maximizing contribution towards expected goals.	
1.1.2 Reported measures, adaptive management strategies and contingency plans designed to ensure the relevance and **adaptability of the model of the Partnership to different and changing contexts**, while considering the development-humanitarian nexus. **1.1.3** Views and experience of UNFPA staff at global, regional country levels, partners and health authorities at global and national level, and multilateral/bilateral partners regarding **the adequacy of the Partnership´s approach and design to adapt and innovate** to achieve expected goals in a diversity of contexts. **1.1.4** Key stakeholder experiences and opinions on the extent to which the **Partnership successfully responds to cases of new global health challenges** at country or regional levels.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
As a UNFPA SP implementing partner and active NGO working with youth, NAYA has been **mainstreaming the adolescent sexual and reproductive health (ASRH) agenda** at county level to promote buy-in. Development of the family planning Policy has made progress; however, opposition from religious groups has stalled the process due to the clause around providing FP to adolescents. Legal actions have been taken against health workers. They have also faced opposition from some in the MoH, which has led to fear among healthcare workers to provide SRH services to adolescents	KII with NAYA. October 2024.
There is **no standardized approach to monitor the process of Compact implementation**. FP2030 is supporting countries to translate the compact into action plans, and to collect data and analyse it in-depth. Supporting countries to have a data-centric oversight over the Compact and action plans implementation. The FP2030 M&E group in Washington helps countries do a deep dive (whenever a new DHS comes out) to interpret their data and strengthen accountability.	KII with FP2030. October 2024.
Challenges with the Partnership are how to collaborate more with UNFPA and partners, support each other, and build sustainability. There is a Compact, but they also have an MoU with key SRH partners – different contributions, different mechanisms. **Can't all the donors just pool the funds to enable Government to use them?** Challenges include: - There is a percentage that is to be paid by Kenya, but the **country is not ready**, they haven't built their systems enough - **Procurement is taken over by UNFPA**, which is counterproductive and weakens Government systems. Why can't they just procure themselves, as Government? - **Funding model** – Funds are in the hands of UNFPA, and MoH is only there "to do the paperwork". Why can't funds be channelled through government systems?	KII with MoH SRH and FP tech team. October 2024
UNFPA approach to working with KEMSA has evolved from the model used during the Supplies Programme to a **more direct and integrated engagement.** This approach involves UNFPA procuring SRH commodities, while KEMSA manages their storage and distribution across Kenya. The new approach to the engagement between the UNFPA supplies partnership and KEMSA has **strengthened Kenya's supply chain for SRH commodities.** By integrating **innovative tools** like the Integrated Logistics Management Information System (iLMIS) and the Electronic Proof of Delivery (e-POD) app (awarded "best innovative health supply chain solution" at the Global Health Supply Chain Summit in 2021), this approach has **enhanced real-time tracking, accuracy, and accountability** in the storage and distribution processes. **Strategic partnerships**, including collaborations with Coca-Cola Africa, have improved	KII with KEMSA. October 2024

Assumption 1.1 The Partnership approach, with a focus on sustainable financing and framed as a partnership, includes **relevant measures to ensure the effective** adaptation to different and changing contexts with a view to maximizing contribution towards expected goals.	
logistics and last-mile delivery, **making commodities more accessible** even in remote areas. The coordination matrix at KEMSA has served as a **strategic framework that involves multiple stakeholders**, including UNFPA, MoH, NCPD, and various donor agencies, **facilitating collaboration and communication across the supply chain**. UNFPA ability to **source family planning commodities at competitive prices on the global market has lowered costs**. UNFPA through the Supplies Partnership has **catalysed other partners in supporting the strengthening of supply chain for health commodities.** While the current approach has notable strengths, several **challenges** have been identified. Despite UNFPA support, **issues like stock-outs and delays in receiving commodities continue to affect service delivery**. For instance, health facilities and end-users desire access to products like DMPA-SC, but periodic **shortages limit their availability**. Additionally, only 35 of Kenya's 47 counties have received training on the Logistics Management Information System (LMIS), which restricts consistent implementation and monitoring across the country.	
The donors have been **phasing out of family planning support for Kenya**, as Kenya is a lower middle-income country (LMIC), and was no longer eligible. Then **new product introductions (implants) went well**, demand was high, but there were **gaps in product availability**. So, they (CHAI) worked with Government, partners, UNFPA, other stakeholders to devise best practices, including **demand generation**.	KII with CHAI. October 2024
As a development partner/multilateral donor, FCDO works with UNFPA SP mainly around **policy, pushing government commitment** related to the Country Compact. They are part of the donor focal point group for the FP2030 MoU – which stipulates that FP indicators (around unmet need, etc) should reach 100% by 2026. They do not get routine updates from Supplies Partnership; but communications are "more reactive". (UNFPA should give regular updates to FCDO, they feel). They do **commodity launches with UNFPA SP, to build awareness** in Kenya; they join UNFPA for field visits (e.g. **last mile assurance visit**) to ensure products are reaching the facilities and communities. They work with the UNFPA SRH/Youth Advisor and family planning/RHCS Specialist at UNFPA Country Office on programmatic activities, field visits, etc. FCDO does a lot of work around service delivery, training, and increasing method mix.	FCDO interview October 2024
In partnership with SP, they are scaling up availability of DMPA-SC in Kenya. There is an increased focus on and **utilization of data for decision-making**, through membership in the **Global Family Planning Visibility and Analytics Network (VAN).** Challenges include dis-synchronization between the financial calendar of UNFPA (Jan-Dec) and the Government financial year and timing of quantification (Jul-Jun) causes **misalignment in the timing of funds disbursement**. This contributes to delays. LMA assessments and SRAT do not flag the **upstream challenges in the flow of funds** that **contribute to the supply chain disruptions and demotivation of HCWs**.	KII with In Supply. October 2024
There has been much more **representation** (a big shift from the 9th to the 10th country programme) and engagement with CSOs in the Supplies Partnership, leading to the participation of the ICRH-Kenya as a member in the UNFPA Supplies Partnership **Steering Committee**. This participation carries with it the responsibility of representing CSOs from the entire continent and beyond at the steering committee. Unfortunately, the coordination of this representation has not been properly supported and organized by UNFPA. Ideally, when ICRH Kenya attends the quarterly Global steering committee meeting, it needs to carry the	KII with ICRH-K. October 2024

Assumption 1.1 The Partnership approach, with a focus on sustainable financing and framed as a partnership, includes **relevant measures to ensure the effective** adaptation to different and changing contexts with a view to maximizing contribution towards expected goals.	
voices of other CSOs in the globe, their best practices, challenges, and lessons. UNFPA can **leverage its coordination power to convene such consultative processes among CSOs in Africa**. The intention to have country representation was good, but it hasn't been very effective - she didn't have a strong enough platform to represent the collective views of all member countries of the SP (or even all of Africa, or all of Kenya). There is **no mechanism to do this** - to enable one rep to be able to speak for the whole constituency (all countries). There should be a way to capture the voices of other countries. The Supplies Partnership has significantly **strengthened the government's commitment to allocating budgets** for family planning commodities. Through targeted **smart advocacy efforts** and the suggested matching fund mechanism, UNFPA has played a crucial role in **advocating for the prevention of stock-outs** of essential family planning supplies. UNFPA has supported **comprehensive supply chain visibility**. The partnership has developed **training packages** specifically for New and Lesser Used commodities and for self-care guidelines and policies, enhancing method mix and giving individuals choices that meet their specific needs.	
Initial counterpart funding between MoH and key FP partners (USAID, FCDO, BMGF) was based on an MoU and dependent on the goodwill of the PS, and availability of funds. Similarly, agreements with UNFPA were through MoUs and other agreements since 2007. These were **not legally binding**. Ring-fencing of funds for FP required Treasury to sign and approval from the Attorney General. Hence **the Compact is more binding for the government.**	KII with Options. October 2024
The Steering Committee (SC) is a good addition, and it is **good to include country representation**. But UNFPA should consider having **more country voices** on the SC, including MOF/Treasury/Government representatives.	KII with BMGF. November 2024
As part of their MoU agreement (MoH, FCDO, USAID, BMGF), different **partners were engaged to mobilize and fill gaps**. USAID engaged with UNFPA to increase choice in FP commodities, including procuring DMPA self-injectable while the Government was/is still not paying. (This while they continued to push the Government to pay, according to their commitments). (DMPA was procured by Government previously).	KII with USAID. November 2024
UNFPA involved Nation Media not only for reporting but also for **lobbying and policy advocacy** for increased SRH services in Kenya. The One Health Podcast bi-weekly (which also runs on NTV website and on their YouTube channel and other social media including Facebook and X) was on family planning approaches, with adapted content according to the audience and the information from UNFPA. They produced **four podcast episodes** of 45-60 mins on family planning as a key driver of socio-economic development. These were done in May, June, July, and Aug 2024, to build momentum to World Contraceptive Day on 26 Sept. The approach used through the **partnership is very innovative and has resulted in the production of several products**. For example, they developed a **media toolkit** for journalists on reporting on family planning.	KII with Nation Media. October 2024

Assumption 1.1 The Partnership approach, with a focus on sustainable financing and framed as a partnership, includes **relevant measures to ensure the effective** adaptation to different and changing contexts with a view to maximizing contribution towards expected goals.	
UNFPA has been more **open to collaborating with partners** such as the Population Services Kenya in implementing various activities as part of the Supplies Partnership. These include advocacy (smart advocacy), capacity building, planning, and conducting the last mile assessments. PSK has a **workplan that is aligned with UNFPA** and FCDO (in order to collaborate and not duplicate) and the collaborations of the last two years have been much stronger. The total market approach (TMA) is being used in the Partnership's work with PS Kenya. The new **Partnership approach has helped to increase the reach** of family planning commodities and service delivery. The approach has brought opportunities for organizations to explore new ways of engagement and supply of commodities especially in the **private sector**. The FCDO DESIP programme comprises PSK, Options, and UNFPA. FCDO funds both DESIP and the Supplies Partnership. DESIP ends in March 2025 (with no follow-on expected) - this could be **a "looming crisis" for FP in Kenya**. Procurement for the Partnership is done through UNFPA SCMU.	KII with PSI-Kenya (PSK). October 2024
The main change, with the Partnership approach by UNFPA has been the introduction of the **Country Compact** which indicates that the national **government should commit to contribute** a certain amount of money (percentage of UNFPA budget for FP commodities) to UNFPA for the procurement of SRH/FP commodities. Since 2021, UNFPA has introduced and advocated for the **signing of the country compact**, the introduction and advocacy efforts towards the implementation of the h**uman rights-based approach** and **Standards to family planning**. UNFPA Kenya has been active in the Supplies Partnership, by supporting and driving the development of the integrated logistics management system **(iLMIS**) by KEMSA. The development of the iLMIS was possible due to UNFPA facilitating the establishment of a public-private partnership (PPP) between KEMSA and Coca-Cola. UNFPA has also been active at **convening stakeholders and advocating for domestic financing** of SRH commodities (e.g. the implementation of the smart advocacy initiatives). In addition to **ensuring commodity security for family planning products and strengthening supply chain systems**, UNFPA has invested in the **capacity of the key stakeholders** that work to ensure **commodities reach the last mile**. UNFPA Kenya does not work alone but in collaboration with partners that operate within the family planning space, including CHAI, FP2030, FCDO, Bill and Melinda Gates Foundation, Marie Stopes, and others. The Partnership approach resulted in the **signing of the country compact**. UNFPA has been able to **contribute to the expansion of the supply and delivery of family planning commodities** (e.g. introduction of self-injectable (DMPA-SC).	UNFPA Rep and key Staff meeting. October 2024

Assumption 1.1 The Partnership approach, with a focus on sustainable financing and framed as a partnership, includes **relevant measures to ensure the effective** adaptation to different and changing contexts with a view to maximizing contribution towards expected goals.	
With this approach UNFPA has also been able to **leverage the influence and presence of other partners in the family planning space**, leading to division of labour. For example, advocacy activities for demand generation are led by other partners like Marie Stopes, with support from UNFPA. UNFPA worked with CHAI, within the National Task Force, to advocate for the roll-out of the DMPA-SC and the Hormonal IUD. UNFPA also worked with This Ability Trust on the roll-out of the ***"Mama Siri"*** effort (a toll-free line that offers referral services for women living with disabilities on GBV and SRH; run by women with disabilities, and started in 2020 in 8 counties, adding 5 more counties last year). They also advocated for the **inclusion of disability** in the reporting tool of the MoH in Kenya.	

Assumption 1.2 The existing **approach for grouping and classifying countries for their eligibility** and inclusion in the Partnership, including the type of support received and country ceiling approach, is sound to secure a pathway to sustainable transition. (Linked to theory of change causal assumption 8)	
Indicators **1.2.1** Documented report alignment between countries classification and type of support (country stage) provided with declared country needs and relevant health-related strategies. **1.2.2** Limited and justified discrepancies (surplus, gaps) between established country commodity allocation and ceilings based on existing indicators and the declared country needs. **1.2.3** Views and experiences of UNFPA staff at global, regional and country level; views and experiences of partners and health authorities at global and national level about the relevance of the existing system to classify and define support provided to countries.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
The **classification of countries** is not the best suited approach for Kenya. The averages of the country's indicators seem to show that Kenya is doing well, but the reality on the ground is very different, and there is very **wide disparity** between regions and counties. (Some are like "Europe" and others like "Niger" in their indicators).	UNFPA Rep and key Staff meeting. October 2024
The **classification of Kenya as a carry-over country** does not reflect the ongoing reality. It seems like a problem of averages that made Kenya look like it is doing well. The approach is **standardized across 54 countries, but did not take into account realities** on the ground – e.g. in-country variation: very low CPR in some places, much better in others; in addition to financial challenges, country context (averages for country look adequate, but hide problems in the worst areas).	KII with UNFPA CO SRH specialist. November 2024
The **Compact is too much of a cookie cutter approach**, treating all 54 countries the same, when their **capacity and context are so different**. The Compact came in while there was still an MoU for family planning with key partners (FCDO, USAID, BMGF). The Compact should have more aligned with the MoU, and UNFPA is acting like Kenya is starting from zero, whereas it should have been building from what was already under way in SRH/family planning in country, and work to build on national systems (not create parallel ones). The Compact should have offered incentives to bring in new products. Governments (including Kenya) are procuring essential medicines, so they do have capacity. By **taking procurement out of Kenya** (handled by UNFPA SCMU), **they are not strengthening national systems**. They must work within the system, if want to build sustainability.	KII with FP2030. October 2024

Assumption 1.2 The existing **approach for grouping and classifying countries for their eligibility** and inclusion in the Partnership, including the type of support received and country ceiling approach, is sound to secure a pathway to sustainable transition. (Linked to theory of change causal assumption 8)	
Kenya: "Carryover" Country: From 2022, all Partnership countries will be **assigned to one of five groups** (Group 1, 2, 3, 4 or the Carryover Group) using an economic index. Country groupings will be used **to determine the level of commodity support** that each country receives and the domestic financing contribution that needs to be made towards the cost of commodities from 2023 onwards. From 2022-2025, **Kenya will be classified as a "Carryover" country. This means that the Government of Kenya will need to contribute at least 10% towards the cost of routine commodities provided by UNFPA Supplies in 2023.** This financing contribution is expected to increase by a minimum of 10 percentage points per year. Country groupings will be revisited every three years in light of new economic data, with the next review process taking place in 2024 for implementation in the 2025 calendar year.	UNFPA (2022). UNFPA Supplies Budget Allocation Letter Kenya 2022.

Assumption 1.3 The **existing funding streams** (supplies, HSS and MAV) and **sub-streams are designed to reinforce each other** and contribute to achieve Partnership results with a focus on a system strengthening approach to improving commodity availability. (Linked to theory of change causal assumption 8)	
Indicators **1.3.1** Levels of **funding allocation by main funding stream** (and sub streams, including the humanitarian contingency plan, the match fund, and others) and evidence of re-allocation across streams in response to changing contexts and/or with a view to creating synergies. **1.3.2** Extent to which the three levels of resource allocation considered in the design of the Partnership ensure that resources are directed where they are needed most and where they can make the biggest difference to accelerating the achievement of Partnership goals. **1.3.3** Documented examples of resource allocation decisions constrained or limited by the existing allocation formula (75% supplies, 15% HSS and 10% MAV). **1.3.4** Extent to which programme support allocated in accordance with the current allocation formula matches the needs and national context as identified in situation analysis and planning documents. **1.3.5** The **LMA approach is adequately addressed and funded** through the existing MAV and HSS funding streams for its implementation. **1.3.6** Views and experiences of UNFPA staff, implement partners at global, regional country level, as well as Steering Committee and subcommittees' members on the adequacy of the existing funding streams and sub-streams to achieve expected results.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
The **Match Fund is good in theory**, but this is a constrained fiscal space, in Kenya. Government is paying 80% of their funds to pay down their debt (invested in Euro bonds?). (So, Government isn't making their required contributions, so **not eligible for Match Fund** yet).	KII with CHAI. October 2024
	UNFPA (2022). UNFPA Supplies Budget Allocation Letter Kenya 2022. (pg4)

Assumption 1.3 The **existing funding streams** (supplies, HSS and MAV) and **sub-streams are designed to reinforce each other** and contribute to achieve Partnership results with a focus on a system strengthening approach to improving commodity availability.
(Linked to theory of change causal assumption 8)

Table 2: Indicative UNFPA Supplies Budget Allocation to Kenya in 2023 and 2024

Budget Category	2023 Indicative Allocation	2024 Indicative Allocation
Reproductive Health Commodities		
Routine Commodities	$390,228	$390,228
New and Lesser-Used Commodities	TBC - upon request	TBC - upon request
Match Fund UNFPA Contribution	Up to **$1,500,000** *available from Jan 2022-Dec 2023 and requires government contribution of up to $375,000	TBC
Domestic Fund Contribution Requirement from Government	$39,023	$58,534
Managing Accountability and Visibility		
Human Resources	TBC	TBC
Facility Surveys	TBC	TBC
Transformative Action		
Transformative Action Grant Funding	$200,000-$800,000	$200,000-$800,000

2023 Budget allocation - Transformative Action (TA) An amount of USD 530,000 has been approved and transferred for support in the following areas: a) strengthen supply chain systems, b) diversify sustainable financing, c) strengthen the policy environment for commodity security and choice of methods, and d) seed funding for expanding women's access to new and lesser used commodities through the TA funding stream.	UNFPA (2023). UNFPA Supplies Budget Allocation Letter Kenya 2023. (pg2)

Assumption 1.4 The Partnership is clearly **founded on human rights, gender equality, and the LNOB principles**.
(Linked to theory of change causal assumption 9)

Indicators

1.4.1 Human rights-based approaches and gender transformative approaches are embedded within the design of the Partnership and effectively implemented.

1.4.2 LNOB principles are embedded within the design of the Partnership and effectively implemented.

1.4.3 Views and experiences of implementing partners and right-holders´ organizations on the strength of human resources, gender equality and LNOB principles in the design of the Partnership interventions.

OBSERVATIONS	**SOURCES OF EVIDENCE**
UNFPA appears "a **bit stretched" (staff, resources**) and needs to prioritize. Maybe they need some structural changes. They are overwhelmed. They work with other donors/partners, but they are not a large staff.	KII with FCDO. October 2024
The SP has diversified its engagement to not only supply chain management (SCM) but also other avenues with different implementing partners (Ips). For instance, UNFPA has worked with This Ability Trust on the Mama Siri, a toll-free line that offers referral services for women living with disabilities on GBV and SRH. It is run by women with disabilities, and started in 2020 in 8 counties, adding five more counties last year. The focus is **LNOB principles, enhancing access.**	KII with This Ability Trust (group interview). November 2024

Assumption 1.4 The Partnership is clearly **founded on human rights, gender equality, and the LNOB principles**. (Linked to theory of change causal assumption 9)	
This approach has resulted in an **increase in the coverage of beneficiaries that can access SRH services and commodities**. Women living with disabilities can now better access family planning commodities.	
A collaborator and new IP of the Supplies Partnership in Kenya is the Kenya Human Rights Commission. The Commission's work focuses on **human rights for marginalized populations**. Their **SRH and SGBV thematic area focuses on human rights in SRH in the health sector**. The populations considered marginalized include ethnic minorities, children, persons with disabilities, older people, women, youth, lesbian, gay, bisexual and transgender and others in humanitarian and other settings. They work with UNFPA (previously as a Collaborator, now (Nov 2024) as a new Implementing Partner – with some activities due before year end) in the **promotion of the right to health and sexual and reproductive health (SRH), using a human rights-based approach**. As an Implementing Partner, their role can grow, especially with the new Social Health Insurance plans coming online.	KII with Kenya Human Rights Commission. November 2024

EVALUATION QUESTION 2: To what extent is the Partnership effective at **increasing availability and choice of reproductive** health and family planning commodities for all women who want and need them, including marginalized groups and those in humanitarian situations, through the Partnership strengths in global forecasting, procurement, quality assurance, and delivery?					
CRITERIA	Effectiveness/ coverage	**AREA OF INTEREST**	Strategic objective 1 – Availability and Choice (supply dimension)	**LINKAGES TO THE THEORY OF CHANGE**	Linked to the green boxes for strategic objective 1 in the middle of the theory of change.
RATIONALE	This evaluation question focuses on assessing the **contribution made to the achievement of strategic objective 1 about increasing the availability and choice of quality-assured reproductive and maternal health commodities**. Given the strong focus of the Partnership on availability (75% of funds) versus access (15% of funds), this area of investigation strongly emphasizes the supply dimension of the Partnership and the interlinkages between strategic objective 1 and the other strategic objectives. These interlinkages (and particularly with strategic objective 2, also focused on the supply dimension) highlight the broader impact of improving availability on various facets of reproductive and maternal healthcare, ultimately contributing to a more robust healthcare system. Additionally, by focusing on supply chain efficiencies, the Partnership aims to create a sustainable and scalable model that not only addresses current gaps but also anticipates future demand in reproductive and maternal health services. The question examines the strength of the Partnership procurement planning and efficiency, while addressing UNFPA market-shaping capacities. Additionally, the related key assumptions also test the provision of a wide range of high-quality SRH commodities to countries, including in humanitarian settings. Finally, the question also addresses the adaptability of the Partnership to distribute routine commodities as well as new and lesser-used commodities across different country and regional contexts.				

Assumption 2.1 The Partnership collaborates with national authorities and partners, leveraging its global reach and purchasing power to negotiate with suppliers and manufacturers for the **efficient and timely forecasting and procurement** of high-quality reproductive health/family planning commodities, to respond to country demand. This effort helps shape the market for these products, positively impacting quality, price, innovation, and supply.	
Indicators **2.1.1** Reproductive health **commodities by type and volume** (including dollar amounts) procured and shipped to partner countries (per their requests/orders) by the Supplies Partnership over time. **2.1.2** Records of **coordination meetings and consultations** to identify goals and determine negotiating positions prior to contracting with global suppliers. **2.1.3** Functioning mechanisms/processes for forecasting demand for and planning timely delivery of selected quality reproductive health/family planning commodities, including through coordination efforts with other in-country partners. **2.1.4 Trends over time in prices and choice** of products available for a sample of reproductive health/family planning commodities as identified in long and short-term agreements. **2.1.5 Functioning mechanisms/processes** for quality assurance and quality control for commodities/products procured and shipped with support of the Partnership. **2.1.6** Downward trend in **instances of sub-standard quality and delays** in shipment of products/commodities. **2.1.7** Examples of **innovation in reproductive health/family planning commodities** and products procured. **2.1.8** Stakeholders' perception of the **Partnership's ability to forecast and procure** Reproductive health commodities, and to influence and help shape the market for these products.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
MSI-K were brought in by UNFPA as service providers to **promote access to NLU, particularly permanent methods.** They trained 48 healthcare workers (doctors, nurses, reproductive health clinical officers): 24 to provide BTL, 24 in performing vasectomy. They trained HCWs (doctors, nurses, clinical officers) based in Nairobi, Bungoma and Narok. They also **ensure quality of care** through follow-up visits to ensure practitioners adhere to standards of practice. They reported that the trained HCWs sometimes experience challenges with availability of medical supplies and equipment to provide the services. They are collaborating with MoH through ToT trainings to integrate the services in public sector facilities for sustainability. MSI also works in the 5 UNFPA priority counties to promote access to post-abortion care (PAC) services and empower community health promoters (CHPs) to raise awareness of these services in their communities. **LMA** - UNFPA provided support to MSI to ensure that a facility which was 500km from Isiolo town received family planning commodities. An MSI logistics staff member accompanied this delivery to the hard-to-reach facility (and noted the health workers were very appreciative of the support). She noted that the family planning commodities do reach even these very remote facilities! (This one was the hardest to reach, the most challenging for supply chain management). The county team then decided to do an "adopt-a-facility" approach with this remote facility, so the county will now train and support them.	KII with MSI-K. November 2024

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Humanitarian: UNFPA supported MSI to carry out a survey in Kakuma and Daadab refugee camps to assess access to SRH services and identify challenges encountered. The survey highlighted challenges with unavailability of stocks, limited health care worker skills in family planning service provision. UNFPA supported MSI to procure 530 manual vacuum aspiration (MVA) kits for PAC service delivery. These were to complement a training that had been conducted at health facilities through the support of another IP; however, the resources were not adequate to provide equipment to the facilities. So UNFPA supported procurement of the kits, and MSI funded their distribution. Currently follow-up is under way on this activity.	
UNFPA has been supporting outreach services of implementing partner the Kenya Red Cross Society. UNFPA has given part of the allowance for reaching remote areas as most of the facilities are not close by. This support from UNFPA **included community engagement and messaging** as well as **procurement of informational materials and customized messaging**. Since 2021, Red Cross feels that there is better programmatic and implementation coordination with UNFPA and the Partnership. There are always discussions and ways to further improve the implementation. Red Cross works under the **Humanitarian line on UNFPA budget** and workplan. Red Cross has monthly and quarterly meetings with UNFPA (Humanitarian officer of long standing), and discuss reproductive health/family planning commodities with Charity at Country Office.	KII with Red Cross Society. November 2024
Support to MoH (an implementing partner) comes from UNFPA for family planning commodities, and the Government is involved. But it is **not a smooth provision**, and there are **interruptions in availability of products**. **Forecasting** is done for the whole country - for all counties, public and private sectors. It is not a smooth supply of products, and products are not always available. Service delivery is managed at different levels – availability depends on the products, but also training and capacity building of health workers, advocacy at various levels, and strengthening of SCM systems.	KII with MoH SRH/PR technical team. October 2024
Kenya had a pre-existing forecasting system for all medical commodities. The **Compact did not integrate into the pre-existing medical commodities procurement system** in the country; but **created a parallel system for procuring family planning commodities** as opposed to strengthening the pre-existing system. This is a “step backwards for Kenya” and does not help to strengthen Kenya’s systems.	KII with FP2030. October 2024
All partners support Government to do the **national forecasting for family planning** (biannually), with UNFPA, CHAI, and others working together to ensure the pipeline of products will meet requirements. Together they develop the **National Supply Plan**. Now the Partnership all work together with the Supply Plan and using the VAN system (data on global supplies), so they are all on the same page. The KEMSA LMIS was built onto another system. The KHIS was reporting on consumption and patients. The LMIS was a supplies/issuing system. These needed to integrate/connect, to determine how much supply should go to each health facility. There were workshops with UNFPA, KEMSA, CHAI and others to work on **enabling visibility/connection** to the KHIS system from the iLMIS system, to be able to pull data from the KMIS to help inform the LMIS. A **rationalizing of the ordering process** has been done, so that health facilities are no longer ordering randomly as they wish. They now do quarterly ordering, based on their needs and consumption.	KII with CHAI. October 2024

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The stock problems evident in the LMIS (the red and brown bars indicating shortages) used to be a lot worse (so there is improvement). There has **not been Government money for family planning commodities** "in some time". Health facilities order quarterly from KEMSA and receive their commodities in the next month (if they are available).	
When **FCDO procures commodities, they consult with Government Then UNFPA (through SCMU) procures** (1x per year) on their behalf. Then the products go to KEMSA for storage and distribution. [There have been many scandals at KEMSA over the years (and a big scandal with MoH in ~2018), so trust is an issue there. The old KEMSA CEO was fired, and there is now a new one, and there is hope that things will improve]. There are "lots of gaps" in tracking commodities to the health facilities. Also KEMSA has a heavy debt (5B Ksh) from counties who have not been paying them. The Global Fund does procure (as well as store and distribute) through KEMSA, but USAID, UNFPA, and FCDO do not. (They merely let KEMSA store and distribute). FCDO procurement is meant to fill gaps, e.g. when stock-outs or shortages occur. They get quantification reports from MoH and can react to the issues happening with stocks. E.g. there is a shipment coming in next month (of Jadel), which will be launched at KEMSA and then go out to where it is needed. FCDO **works with community health promoters** (CHPs) to do community-based distribution in the 12 counties FCDO works in. FCDO **works on commodity launches with UNFPA SP, to build awareness and demand**	KII with FCDO interview. October 2024
UNFPA support towards the **development of the integrated LMIS has helped with improving forecasting and procurement** of SRH commodities. The UNFPA procurement system is good re: **access to good prices and innovative mechanisms** like the Match Fund and Compact (really great to have this commitment from Government).	KII with ICRH-K. October 2024
The **UNFPA Supplies partnership has played a leading, catalytic role in supporting (both technical and financial) the development of the Integrated Logistics Management Information System (iLMIS) at KEMSA**, which went live in May 2023. The web-based system comprises three main components: the Commodity Early Warning and Alerts System (CEWAS), an allocation system, and the Electronic Proof of Delivery (e-POD). It is designed to ensure that commodities are delivered on time, in full, and error-free. The iLMIS features a dashboard with 45-60 indicators to monitor performance. It is a proactive decision support system for all national family planning commodities. <u>Forecasting and feedback mechanisms</u>: There is a Quantification module within the CEWAS which ensures visibility of commodities to the last mile, **minimizing wastage, including expiries, overstocks, damages, and pilferage, and aids in forecasting based on consumption** patterns. Minimum stock thresholds and targets are set within the system to help identify when procurement is necessary. UNFPA is part of the National Order Management Team (NOMT), which utilizes this information to stay informed about procurement needs, particularly when commodities fall below the established minimum thresholds (e.g. availability of enough stock to last 1 year). Ideally, 16-22 months' worth of stock should be on hand at all times. The system can see down to health facility level, showing (in colours) the levels of stock at each (red, brown, green). The system also measures wastage/losses in supply chain, so that these can be minimized. Losses should not exceed 1%.	KII with KEMSA. October 2024

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There are 4 levels to the system at KEMSA: Policy framework, processes in the system, technology, and people/coordination team. The **Supplies Partnership helped with expansion of routine commodities and new and lesser used family planning products** (NLUs) in Kenya by enhancing the **availability and accessibility of essential SRH supplies**. Through strategic collaborations with the MoH, UNFPA has facilitated the **efficient procurement and distribution of various contraceptive methods**, including injectables, implants, and condoms. **New products** such as the DMPA-SC have been introduced through the Supplies partnership. UNFPA is an authoritative, credible leader of information and programmes on family planning, so through its advocacy efforts, working with partners such as ICRH-Kenya and Marie Stopes, UNFPA has been able to **influence the expansion of routine commodities and NLU products**. New products have been introduced such as the DMPA-SC which has been very well received. UNFPA ability to **source family planning commodities at competitive prices on the global market has lowered costs**. UNFPA through the Supplies Partnership has **catalysed other partners in supporting the strengthening of supply chain for health commodities.** UNFPA procures their own products (through SCMU), and thanks to the iLMIS, KEMSA can plan and see what is coming in the pipeline, helped by the National Order Management Team (NOMT) of MoH, development partners, implementing partners, KEMSA, UNFPA and others. The development of the iLIMIS has helped **ensure that there is adequate supply** of routine commodities	
Availability of commodities is being **hampered due to shipment delays** (e.g. DMPA-SC) at the stage of freight forwarding which is solely under UNFPA purview. Cause of the delays is not well understood (Pfizer and freight forwarder in Belgium?). This is a **setback for product availability across countries**. Sometimes emergency orders have to fill the gap. Kenya usually develops a **quantification and supply chain plan** based on identified needs. However, there's a **disconnect in communication between MoH, UNFPA, and SCMU** (Geneva) which causes delays in placement of orders and availability of family planning commodities.	KII with In Supply. October 2024
UNFPA and USAID participated in a **global meeting in Oct 2024 (virtual) on how to collaborate in family planning globally**. UNFPA sent USAID a survey with questions beforehand. (results/outcomes? Report to come). Service delivery: USAID is not working with UNFPA at this level, but only at national level (where they work closely with UNFPA). USAID funds UNICEF to work in the northern ASAL (arid and semi-arid lands) regions of Kenya, and in the refugee camps there (focusing on family planning, and GBV). Procurement: USAID procures family planning commodities through the Global Health Supply Chain – Procurement Supply Management (GHSC-PSM) project, then commodities go to KEMSA (only for family planning). MoH controls and determines where the products go. USAID uses another organization ("Meds" – a Catholic entity with barriers around family planning products) for ARVs and other products outside the family planning programme. USAID works across 13 counties, measuring couple years of protection (CYP), and funding various projects to increase demand for all RMCAH products, not just family planning. They use an integrated approach.	KII with USAID. November 2024

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Timing – sometimes delivery of commodities is not on the predicted timeline (does the Supply Plan including detailed timelines?). Financial year complexities are a factor (Kenya Government financial year is July-June). There should be more advance discussion (before procurement) around tax, financing, pipeline timing, arrival process, etc. Quality is compromised when there are delays or orders are wrong. Availability and access: they have had **success with some methods (some have more stock-outs** than others). It is rare to stock on IUDs (uptake is low – potentially a skills issue, or requirement for more information/education), but implants do stock out. There is a **huge increase in demand for implants** – thanks to targeted programmes by partners, CSOs, UNFPA, development partners on long-term methods. There is **good coordination among partners** when there is a **new product introduction** (e.g. DMPA self-injection – with pharmacy training) but need to broaden these coordination activities to include pills, and all family planning methods. It would be better to have coordinated trainings covering all methods, rather than having such targeted events only. "Lessons are being learned" within the Supplies Partnership, but there **needs to be a framing of things more comprehensively**, across methods, to really increase choice. This should be framed as accelerating access.	KII with BMGF. November 2024
-UNFPA and MSI have supported the health facility through supply of equipment required for VSC, training of various cadres of HCWs (RH-Cos, nurses) stationed in high volume facilities in VSC which has enhanced access to and uptake of the services. -Voluntary surgical contraception (VSC) is provided at the facility monthly through booked appointments for the clients; the VSC providers rotate to the different health facilities to do these "in-reach" services -UNFPA and MSI have also supported in quality assurance through supportive supervision visits to the health facilities -UNFPA and MSI have ensured the facility had **adequate family planning stocks; have had consistent supplies**. -However, in the 3 months preceding the meeting, there have been **challenges with stocks of certain family planning commodities** – (Jadelle 5 years, Implanon 1 yr, and COCs); they also have **limited stocks of DMPA-SC**. (They invested in rolling out the new DMPA SC self-injection, generated a lot of demand in communities, and now they are "stuck" without stocks. They are reaching out to KEMSA to see about excess stocks potentially in other counties or sub-counties) -UNFPA supports them through **supportive supervision and outreach in forums** like World Contraception Day, other outreach efforts	KII with Embakasi sub-county Health Center and team (virtual, from MSI). November 2024
Forecasting and procurement of SRH commodities: With support provided through the Supplies Partnership, KEMSA was able to revise the Logistics Management Information System (LMIS) tools and order forms transitioning into the **integrated Logistics Management System** (iLMIS) which includes modules that help with forecasting. The new iLMIS includes a Commodity Early Warning and Alert System (CEWAS),ePOD-Electronic proof of delivery and Allocation System. The procurement is entirely handled by UNFPA, while KEMSA handles the distribution and warehousing. **UNFPA bargaining power helps with the procurement of SRH commodities at a competitive price.** Procurement and delivery process:	UNFPA Rep and key staff meeting. October 2024

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Now that there is a new iLMIS in place, UNFPA does the procurement of the SRH commodities which are delivered to the KEMSA warehouse for distribution and storing. At the KEMSA warehouse, there is a threshold for the minimum stock for SRH commodities which is monitored on the revised iLMIS. The distribution is based on requests made from the counties and sub-counties. There are committees/teams that review these requests before they are sent to KEMSA for action. These committees are the National Order Management Teams, County Order Management Teams and the Sub-county Order Management Teams. The new iLMIS includes the implementation of the On-Time In-Full-Error-Free (OTIFEF) principle. The iLMIS includes the Electronic Proof of Delivery (e-POD) which helps with ensuring accurate and timely delivery of commodities to health facilities. The GPS verifies delivery locations, enhancing order accuracy and reducing order turnaround time (OTAT). Challenges: One challenge faced is that of the disparity/confusion in the unit of measure for commodities between KEMSA and the health facilities and sub-counties. (now rectified?) Another challenge is that many health facilities below hospital level are **still paper based**, so they continue to face challenges in ordering and reporting through the sub-counties. Expanding choice and availability: UNFPA through the Supplies Partnership has advocated with the MoH to **increase the supply of various SRH commodities including new and lesser used (NLU) methods**. UNFPA has supported the training of 100 Trainers on DMPA-SC and 80 Master Trainers from public and private sectors on Hormonal IUD. UNFPA also supported the development and rollout of the National Family Planning training modules on DMPA-SC & Hormonal IUD. UNFPA through the SP has worked extensively with various partners to help expand the availability of routine commodities and introduce NLU products. For instance, UNFPA has worked with partners such as Marie Stopes to introduce bilateral tubal ligation (BTL) and vasectomy. UNFPA has also worked with partners such as Clinton Health Access Initiative (CHAI), USAID, and others to introduce and scale up DMPA-SC and hormonal IUD. UNFPA Kenya SP team has KPIs for their performance. They have been in the Supplies programme since 2007. They have seen **some improvements in indicators**, e.g.: from 2014 to 2022, unmet need for family planning has fallen from 18% to 14%, mCPR has risen from 53 to 57%, and % using modern methods has risen from 71% to 75%. (PPT presentation by Charity)	
Pharmacist & SRH/clinical officer meeting: NLUs get pushed to health facilities, without training the health workers on the method or the reporting. Data management (and quality of data) suffers when health workers don't capture the records correctly. **Visit to pharmacy and stores**: (very crowded, with stacks of boxed products filling the room) – this large room is the shared stores for the county and sub-county.	Narok County - Ololulunga sub-county mgmt. and HF visit (and CHPs and FGD with women beneficiaries). Narok county. Narok County

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The new DMPA injectable was last received in May 2024, and now only 3 boxes (each box contains 18) remain, so they are about to stock out. Nothing has been received in the June-Oct period. The last delivery was in Nov 2023 through a distributor. Tuesdays (the next day) are very busy family planning days, so they were worried about the next day and how they will serve their clients, with their limited stocks. **CHPs interview:** Handles family planning activities in his community (he was trained to provide services to the 100 households he manages (Nashorwa has ~60)). They visit each household once a month, do referrals to health facilities as necessary, give information, counseling, remind them of next visits. For adolescents, they give the health education package, mention family planning, advise them with some privacy. There is no youth-friendly space here or in the communities, but they would like to have that. They take family planning commodities to communities (about 5 kms away), attend to people in their homes. CHPs are well known and trusted in their community, they said. Every month, they collect commodities at the health facility, take them to the community, and track and report on consumption. But sometimes they are stocked out, so they cannot get the products. CHPs across the county have their own app (the "eCHIS" system). The CHPs in get together monthly to discuss issues, challenges, etc. Re: vasectomy (an NLU),CHP said, men fear it, and do not understand the benefits enough. CHPs need more training on this. The CHP manager (Millicent) noted that **stocks of family planning commodities are "a challenge**", especially the short-term methods. She explained that, during outreach, they carry the commodities with them (once they have informed the community), and they bring IEC materials (need more). The DMPA self-injectable has been demonstrated, communities sensitized about it. (CHP Nashorwa provided a demonstration for us, using a condom filled with salt to act as a woman's arm). They need more training so that more CHPs can be CBDs (community-based distributors). They get some training, and refresher training offered to CHPs They are very happy with the new stipend from the Government (a recent government benefit). **FGD with (~10) women beneficiaries:** The women generally agreed that, during their visits to the health facility, they were informed of the different family planning commodities available. They underwent physical examination and received counselling on the different methods available; they also received advice on which options were favourable depending on their physical health. However, only two of them were aware of the DMPA-SC. They reported that education sessions were not held regularly at the health facility, so they had limited access to information. The women voiced their concerns regarding the **disparity in access to information** between those who were based in urban settings vs. those in more rural areas on availability and benefits of using family planning methods. Those who reported side effects during their appointments were counselled on other viable alternatives. Some reported that community-based	

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distributors (CBDs) visited their residential areas; they provided education about family planning methods and distributed them. They also encouraged women to take up the services; however, they had limited information on the side effects of family planning methods. Also, some women reported that they had not received visits either from CBDs or CHPs to educate them about family planning methods in the community.	
The **new iLIMIS is a game changer**, in that it has helped organizations such as RHNK to track the status of FP commodities at KEMSA. More specifically, information on short expiring products available on the iLMIS helped RHNK to make informed decisions on the IUD redistributions. This also supports their public-private redistribution efforts. RHNK is part of the national order management team. Therefore, they have access to information on the short expiry that helps them plan redistribution effectively. The synergy between the HMIS and the iLMIS is a great innovation. **Family planning availability and choice have gone up since 2021** and is not as "up and down" as it was before. Supply is also up overall. Their family planning products: The registration process in Kenya takes time. Products come from IPPF suppliers and through UNFPA. They are also getting some DMPAC through the Government. There is a supply monopoly for DMPAC. **UNFPA has played a big role**, and RHNK benefits from it. The **supply is still not consistent**. **UNFPA is also supporting them on hormonal IUD training, ToT and capacity building** of county Government pharmacists in the private sector. If their private providers need products, they order them through Government (KEMSA).	KII with RHNK. November 2024

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Estimated Annual Requirements by Sector

National Requirements

Product	Share	2022/23 Units	2023/24 Units	2024/25 Units
DMPA IM	100%	3,110,676	3,266,521	3,427,560
DMPA SC	100%	777,669	816,630	856,890
POPs	100%	757,329	760,888	764,236
COCs	100%	5,522,946	5,548,903.85	5,573,319
ECP	100%	1,333,050	1,339,315	1,345,208
LNG Implants – 2 Rod 5yrs	100%	424,874	439,022	453,598
ENG Implants – 1 Rod	100%	424,874	439,022	453,598
LNG Implants – 2 rod 3yrs	100%	212,437	219,511	226,799
Copper-IUCD	100%	127,819	130,580	133,400
Hormonal IUCD (LNG-IUS)	100%	32,184	32,879	33,589
Male Condoms	100%	88,213,930	91,266,132	94,405,687
Female Condoms	100%	453,944	463,931	474,137
Cycle Beads	100%	6,608	6,608	6,608

Kenya MoH (2022). Family Planning Commodities Forecasting and Supply Planning (FASP): Technical Report. (pg15)

Averted	2022	2023
Unintended pregnancies	322,514	188,509
Maternal deaths	851	472
Unsafe abortions	72,433	42,349

UNFPA Kenya CO input to UNFPA Supplies Partnership Annual Report 2022 (2023), pg.3

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<table><tr><td>Direct Healthcare cost saved (USD)</td><td>19,822,391.25</td><td>11,586,172.69</td></tr></table>	
PSI Kenya, procures family planning commodities through UNFPA, with funding provided by FCDO. The engagement of UNFPA with PSK through the SP has led to an **increase in the availability of commodities** in a unique way. Since PSK has a **social enterprise side of its work**, whenever there are stockouts in the public facilities, there is a rise in purchases of PSK family planning products by beneficiaries from the private sector. PSK also import, warehouse and distribute family planning commodities across all 47 counties: they have oversight from end-to-end over their family planning commodities, all the way to the kiosks and service delivery points. Their social franchise arm supplies their own branded family planning commodities - condoms ('trust'), COCs ('femiplan'), injectable ('femiject'). PSK are members of the commodity security TWG; one of the DESIP staff members participated in the VAN training. They are members of the TMA groups that have been **involved in the private sector partnerships to bridge gaps** in case of family planning commodity stock-outs in the public sector. There is a **need to build the sustainability of these groups**. They support strengthening of **data to enhance commodity forecasting**. PSK help counties to **re-distribute commodities** between facilities to enhance availability. With FCDO funding, they collaborate with UNFPA in the DESIP project. They align with UNFPA in implementation and tracking of activities so that they complement each other's activities and avoid duplication PSK support **training of HCWs** on proper insertion of IUDs; and build pharmacists' capacity in family planning through information sharing to enhance their knowledge and understanding of family planning. Together **with UNFPA they supported the formation of the County Order Management Team (COMT**) and are supporting them to hold regular meetings; the plan is that annually they hold three meetings virtually and one in-person. The COMT operationalization has been a struggle - both formation and sustaining their activities. UNFPA supported MoH to **develop guidelines for self-injectable family planning**, and the **pre-qualification and accreditation processes** by the Pharmacy and Poisons Board to make **pharmacies eligible to handle and dispense** these products. The MoH is becoming more open to the concept of pharmacists providing the FP commodities, thanks to advocacy and development of guidelines to enable this (by UNFPA and partners).	KII with PSI-Kenya KII. October 2024
In the last few years, there have been **improvements in family planning commodity security** as a result of **better forecasting and supply planning, introduction of family planning dashboards to track and disseminate family planning products and**	Kenya MoH, Division of Reproductive and

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technologies and efforts to mobilise additional financing for FP products and technologies. Notwithstanding these improvements, financing of family planning products and technologies has been characterised by **significant fluctuations and persistent funding gaps.**	Maternal Health (2020). National Reproductive Health/Family Planning Commodity Security Strategy, 2020/21-2024/25. (pg13)
Number of Total Modern Contraceptives Users in Kenya: Year | Target | Actual (47 Counties) | % Actual(47 Counties) 2021 | 500,000 | 1,733,375 | 347% 2022 | 550,000 | 2,625,986 | 477% 2023 | 750,000 | 2,848,684 | 380% 2024 | 950,000 | 2,388,882 | 251% 7	PowerPoint presentation by UNFPA Country Office for MTE team in Nairobi – Oct28 ("UNFPA SUPPLIES PARTNERSHIP PROGRAMME MID-TERM EVALUATION 2021-2024) (slide #4)7

Assumption 2.2 The Partnership works effectively with national authorities, and other partners, to **expand contraceptive method choice of high-quality SRH commodities** for marginalized groups, in both humanitarian and development settings.

Indicators

2.2.1 Documented increased availability of reproductive health commodities in targeted countries to which the Partnership has contributed, through (a) technical assistance; (b) capacity building and knowledge management; (c) service delivery; (d) evidence generation and dissemination; (e) advocacy.
2.2.2 Documented increased quality of Reproductive health commodities in targeted countries linked to the Partnership, through (a) technical assistance; (b) capacity building and knowledge management; (c) service delivery; (d) evidence generation and dissemination; and (e) advocacy.
2.2.3 Percent of targeted countries where NLU contraceptives have been introduced.
2.2.4 Reported experiences of UNFPA staff and health authorities at central, regional and district levels regarding availability of an appropriate mix of SRH and maternal health commodities.
2.2.5 Stakeholders' perception of the Partnership ability to expand contraceptive method choice.

OBSERVATIONS	**SOURCES OF EVIDENCE**

Assumption 2.2 The Partnership works effectively with national authorities, and other partners, to **expand contraceptive method choice of high-quality SRH commodities** for marginalized groups, in both humanitarian and development settings.	
Advocacy efforts are ongoing, by MoH, UNFPA and partners to build awareness and attention to SRH/family planning as a critical part of health.	KII with MoH SRH and family planning tech team. October 2024
The improved iLMIS uses data from the KHIS, which is broken down by age, so one can see the consumption levels of FP commodities among the youth. **Uptake among youth is on a steady rise**. The problem is with the **method mix - more short-term methods and fewer longer-term methods are available**.	KII with NAYA interview. October 2024
The National Council for Population and Development (NCPD) is a state corporation within the Ministry called National Treasury and Planning. NCPD has 11 regional offices supporting the 47 counties. They are a Government implementing partner of UNFPA in the Partnership. The **SP supports availability and choice** through its support for the iLMIS, trainings, advocacy, participation in working groups, and other efforts with partners including MoH and NCPD. Kenya has been quite progressive on SRH/family planning and has a good method mix of ~13 family planning products. NCPD and UNFPA support the use of LMIS data to inform **efficient use of the resources for family planning commodities** i.e., avoiding overstocking; they support the counties to conduct monthly reporting on consumption. Challenges in operationalizing the tax-exemption systems for FP commodities has caused delays in the past.	KII with NCPD. October 2024
The **SP is not really helping to expand choice and availability of family planning commodities** in Kenya. By 2022, Kenya was procuring 60% of their own supplies, and new products were being introduced. The national forecasting and quantification group negotiated with all partners. This was working, but then the new Government came in, with new people who changed the status quo, and with technical people at MoH now leaving it all up to the partners (and **Government no longer contributing funding**). **So from 2022, it became a donor-funded programme**. And then, in came the Compact in 2023 (bad timing?). CHAI had done a "fiscal space analysis" on MoH, to see where funding for FP could come from, and found some savings there to cover family planning needs. This was good, but then the new Government came in, and it all "fell apart". No one briefed the new Minister around this new funding mechanism. Treasury saw Kshs 500-1B "without an owner" so pushed it out (it was removed/moved to other programmes).	KII with FP2030 interview. October 2024
CHAI "**coordinates a lot with UNFPA" and there is now less duplication across donors/partners**. The Supplies Partnership has worked well, better unified the donors/partners. The PS for Health was convinced (by UNFPA and partners' advocacy work) and is now a champion of FP. The Director General (DG) is also a champion, even in Parliament. (However, there are serious financial constraints, and political/ religious/conservative constraints – the far right is very strong - that are challenges for the family planning programme in country).	KII with CHAI interview. October 2024
MSI **mobilizes champions who are former clients of the permanent family planning methods** to **advocate within their communities to promote uptake of these permanent methods**. They build these "champions'" capacity in messaging to communicate the correct information. They also follow them up to provide continuous support. They also participate in **awareness-raising activities** such as celebrating 'World Vasectomy Day' and action days in the communities to **sensitize**	KII with MSI-K. November 2024

Assumption 2.2 The Partnership works effectively with national authorities, and other partners, to **expand contraceptive method choice of high-quality SRH commodities** for marginalized groups, in both humanitarian and development settings.	
community members and promote uptake of permanent family planning methods. Through the SP support, there has been **increased uptake of vasectomy and BTL because of skilled HCWs and community sensitization** to debunk myths attached to these permanent methods. They have seen **numbers up over the last 18 months (500% increase in BTLs and vasectomies**), with the support and training they offer. These are sensitive areas for communities. But reproductive health is key, in Kenya's Constitution. So they "try to change the narrative". They try to ensure there are fewer backstreet abortions and more medical (rather than surgical) PAC (younger women prefer medical, rather than surgical). They work with journalists and have their own communications department to work on **demystifying and de-stigmatizing** through stories, champions, providing people with a choice. They **work with UNFPA communications person** to identify champions, communicate with journalists, etc.	
UNFPA and MSI have supported the health facility through supply of equipment required for VSC, training of various cadres of HCWs (RH-Cos, nurses) stationed in high volume facilities in VSC, which has enhanced access to and uptake of the services. UNFPA and MSI have also supported quality assurance through supportive supervision visits to the health facilities. UNFPA and MSI have ensured the facility had adequate family planning stocks and consistent availability of supplies. However, in the three months preceding the meeting, there had been **challenges with stocks of certain family planning commodities** – (Jadelle 5yrs, Implanon 1 yr, and COCs); they also have limited stocks of DMPA-SC. (They invested in rolling out the new DMPA SC self-injection, generated a lot of demand in communities, and now they are "stuck" without stocks. Some FP products are stocked out. They are reaching out to KEMSA to see about excess stocks potentially in other counties or sub-counties. The fluctuations in stocks availability e.g., DMPA-SC interferes with uptake after the demand has been created within the community, and clients visit the facility but cannot obtain the family planning product. The approach of MSI-K and Nairobi County to use and train their own staff to administer various methods is a "big plus", as the same team will cascade skills/knowledge to others in the county and beyond (whereas sometimes counties "are like silos," operating alone). The service providers would like more support re: adolescents and family planning, how to deal with young people requesting family planning methods - they need more information in this area. They do **have a youth-friendly space** in their health facility. They could use **more posters/informational materials** with simple images and messages. They also wish for more assistance with **task shifting for clinical officers** (with degrees) to provide SRH services safely. Could there be a study to increase the number of providers who are able to provide BTL and vasectomy as outpatient procedures?	KII with Embakasi HC (NBO county) remote interview from MSI. November 2024
SP has supported the **training of pharmacists as service providers** for administration of family planning products through: ●Policy advocacy for this innovation ●Provision of financial and other resources ●Technical support to facilitate the training ●Support to navigate obstacles to obtain buy-in from regulators on additional scope of work for the pharmacists (without leaving out doctors, nurses)	KII with JHPIEGO. October 2024

Assumption 2.2 The Partnership works effectively with national authorities, and other partners, to **expand contraceptive method choice of high-quality SRH commodities** for marginalized groups, in both humanitarian and development settings.	
Through the Partnership's efforts, a **Pharmacy Training Package was developed** (coming out of the Guidelines), so that trained pharmacists can administer the FP products (and provide counselling, comply with particular criteria for pharmacists to qualify, and report). The (mostly private) pharmacy providers were a missed opportunity, so this is enhancing access. Now other partners have come through to also work on this effort. Demand has gone up, and now they are struggling to streamline the reporting of pharmacists (In Supply, another partner, is supporting in this effort). High turnover in the community pharmacies is an issue, requiring continuous training and oversight. UNFPA SP has been critical in **supporting this effort through policy/advocacy, financial resources, and technical support**. With UNFPA SP support, there has been **increased awareness of the commodities**, of the importance of the **supply side in FP** (not just service delivery!). This gave rise to the **TMA** in country, made the country look at supply, and where to get commodities if the Government is not supplying. Through the SP, UNFPA has been able to **pull together all partners in the space (the "family planning family"**), and the National TWG meets monthly. UNFPA mapped out all FP partners. The consistency shown by UNFPA has been good, e.g. around new methods coming into the country. After the gap analysis was done, they have tried to tie the strategy within the core mandate and Government commitment, aligning with FP2030 and other activities.	
Kenya has a good contraceptive method mix and is also able to track consumption of the family planning commodities. However, **family planning commodities have a long lead time** (~9 mos) as they are manufactured on order; so when orders are not placed in a timely way it contributes to stockouts. The problem he sees: The public sector serves 60-70% of FP needs, so need to ensure the Government are focused on the 60% (most vulnerable). **Government has a challenge meeting the FP needs in the public sector because they also supply the private sector for free** (whereas the private sector then sells the commodities). Why doesn't the private sector buy these products from the commercial sector!? This doesn't make sense, that Government gives them for free. This stifles the commercial sector and reduces availability of FP products in the public sector facilities (the main source for marginalized groups). There is a need to push the private sector to get their supplies from commercial suppliers.	KII with Options. October 2024
The MoH M&E Division's work with the UNFPA Supplies Partnership is on **Health Facility Assessments (HFAs**) and **Quality of Care surveys**. They are working on a statistical sample of 3600 health facilities (focusing on staffing, capacity, services including Family Planning) – Health Facility Assessments for 2023-2024, with support from UNFPA and others including BMGF (main funder), Global Fund, UNICEF. They are still working on the report. As part of the work, they interviewed family planning clients (**client satisfaction survey**)	KII with MoH M&E Dept. November 2024
They started working with UNFPA in 2011. UNFPA supports their Boresha Binti programme (**Adolescent girls programme**) and the Badobinty programme (**focusing on young mothers**). Since 2021, UNFPA has enhanced its support to the Polycom Girls	KII with Polycom Girls. November 2024

Assumption 2.2 The Partnership works effectively with national authorities, and other partners, to **expand contraceptive method choice of high-quality SRH commodities** for marginalized groups, in both humanitarian and development settings.	
through an increased financial investment towards these programmes. UNFPA has also increased its support towards the production of evidence reports and advocacy material for the programme implemented by the Polycom girls. UNFPA supports their Talking Box, assemblies, quarterly meetings with students, teachers and life skills educators. Also with sports leaders, hygiene and sanitation experts, and male champions. With UNFPA support, they have increased the Talking boxes in schools. Initially, there were 10 "Talking boxes" made from cardboard material across Kibera. Through UNFPA investment, there was an increase of 40 "Talking Boxes" made of steel (more secure) and distributed to 40 more schools across Kibera. These are a sort of suggestion box placed in schools for pupils to ask questions, share their concerns or seek help anonymously. Many comments are received (they empty the boxes twice per month). Scaled up with UNFPA support to place them in 60 schools (50 in Nairobi county, 10 in Homabe). They code and capture all the comments (kept confidential/anonymous). Through the Polycom Girls programmes, UNFPA also supports the GPende assemblies, where young girls are reminded that they don't have to keep their problems to themselves, but have an outlet to share them anonymously on paper. Polycom also conducts holiday forums (during school holidays), sports days, messaging, production of sanitary pads for distribution, mentorships and work training, support for teen mothers, training of male leaders, and other activities.	
In Nairobi county Kibera District Dispensary, **women beneficiaries** had **different experiences in accessing their family planning products**. They were offered some choice, and both women interviewed had switched from earlier methods they tried (implants) to now taking the Depo injectable at the HF. However, one received better counselling and choice than the other woman. And one has experienced stock-outs when coming for her appointments every three months to the HF (2 of her 4 visits this year), so has had to go to private pharmacy to pay for her injection. The other woman did not face supply problems when coming for her appointments. **CHPs**: - They normally collect supplies of condoms at the health facility on a monthly basis. They normally get 5 boxes, however, there have been shortages in the 2 weeks preceding the interview so each of them is now allocated 1 box. They also receive reports from their household clients about stock outs of family planning commodities at the health facility. Many of the CHPs are trained to work as community-based distributors (CBDs), and usually distribute condoms, pills, refills for regular clients. But now, because of **stock-outs**, they are only giving out condoms. CHPs have had some training but **need refresher technical modules**. UNFPA gave them some teaching aids, flipcharts, materials to help inform their communities, but there is a need for more.	KII with Nairobi County Kibra District Dispensary staff, beneficiaries, group discussion with CHPs. November 2024
Humanitarian: Red Cross is not part of the National Order Management Committee (NOMT) but should be (MoH needs to invite/appoint them). In partnership with UNFPA, they have reached over 1,000 health workers in the last year, training them on the MISP (minimum initial service package), and facilitating transport and allowances for these HWs to do outreach outside their health facilities. They also facilitate - with Government stipends and UNFPA support - CHPs to work across thematic areas (MCH, family planning, hygiene, etc), and have produced reporting tools for these CHPs as well as an online app for their use. Red Cross has a team who do **last mile and stock management trainings** (e.g. with pharmacists in health facilities) Red Cross has **dignity kits** for girls, Mama kits and others with support of UNFPA. Their RH kits (e.g. #4) contain oral contraceptives, injectables and implants as well as condoms.	KII with Red Cross Society. November 2024

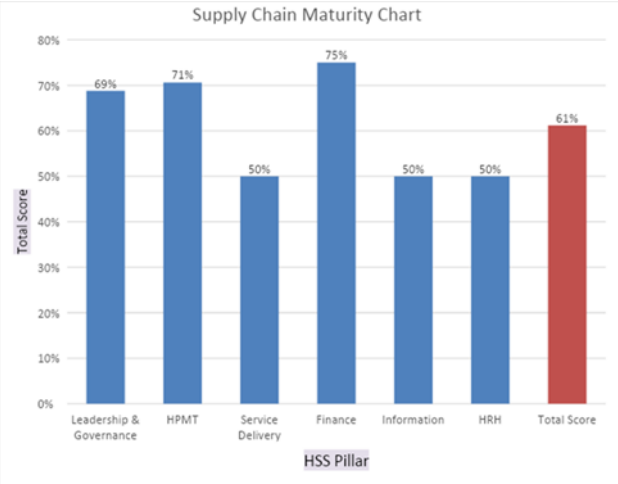
<table>
<tr><td colspan="2">Assumption 2.2 The Partnership works effectively with national authorities, and other partners, to expand contraceptive method choice of high-quality SRH commodities for marginalized groups, in both humanitarian and development settings.</td></tr>
<tr><td><u>Adolescents/SRH:</u> There are safe spaces at community level for adolescents and GBV cases, and RC partners with county Governments to make use of these. They can also do referrals to health facilities as needed. The Red Cross also has emergency ambulances which can reach even the most remote areas.</td><td></td></tr>
<tr><td>The Supplies Partnership has made deliberate efforts to engage the private sector in the conversation on system strengthening for FP commodities. UNFPA is making an effort in bringing on board social enterprises like DKT in its strategic forums such as the Smart Advocacy initiative and the Total Market Approach brainstorming sessions. Through those dialogues they are able to share their experience as well as provide useful information. The private sector entities are usually brought on board for once off activities and are not engaged on a frequent or regular basis.

They have had the DMPA SC and IM from Pfizer, but the consistency of supply has not been good. CHAI, UNFPA and others have helped with raising demand, but supply has been problematic. They also had a pricing issue from Pfizer - Pfizer required a certain committed volume for them to be able to buy, and the price went too high, which would have ruined any margin they would have in the market. The Pfizer access programme for DMPA (not for the commercial market) also has conditions and delays, and its own bureaucracy. (They have stopped being a distributor for this product).
DKT has contracted manufacturers, processes, but need an import permit for each shipment, which delays things substantially</td><td>KII with DKT Healthcare private importer and seller of low-cost FP products. November 2024</td></tr>
<tr><td><u>From PPT given by Charity in Country Office 28 Oct</u>: severe drop in 2023, then rebounding in 2024

<table><tr><th>Year</th><th>Value of Commodities procured through the Programme</th></tr><tr><td>2021</td><td>$2,045,500</td></tr><tr><td>2022</td><td>$3,587,453</td></tr><tr><td>2023</td><td>$1,896,660</td></tr><tr><td>2024</td><td>$4,243,043</td></tr></table></td><td>PPT on UNFPA SP performance in Kenya 2021-2024 (presented Oct28 in Country Office)</td></tr>
<tr><td>Kenya has made great progress towards improving uptake of family planning.
• mCPR has increased from 39% in 2014 to 57% (KDHS)
• In 2022 Unmet need of family planning declined from 18% in 2014 to 14%
Commitments to meet the national targets include:</td><td>Kenya National Council for Population and Development (NCPD) (2023). Inclusion of</td></tr>
</table>

Assumption 2.2 The Partnership works effectively with national authorities, and other partners, to **expand contraceptive method choice of high-quality SRH commodities** for marginalized groups, in both humanitarian and development settings.	
• ICPD25 Nairobi Summit commitments, on zero preventable maternal and newborn mortality and zero unmet need for FP by 2030. • FP2030 Commitments aim to reduce the unmet need for family planning for all women to 10% by 2030	family planning in public health insurance: the potential gains. (pg3)
Expanding choices and new methods: Scale Hormonal IUD and DMPA-SC – UNFPA provided technical and financial support to develop the IUD costed rollout plan, which is **guiding the introduction and rollout of the hormonal IUD in the** county.	UNFPA (2023). Kenya Country Narrative Report 2022. (pg4)
In 2023, UNFPA supported Kenya's Ministry of Health in **expanding access to family planning commodities and services by procuring a range of family planning methods valued at Kenya shilling 711,559,608** [approx. USD 5.5M]. The commodities which included male and female condoms, oral and injectable contraceptives, implants, and IUDs, were distributed to over 6,000 health facilities across the 47 counties, to serve over 2.5 million women of reproductive age. With additional funding from the Foreign, Commonwealth, and Development Office (FCDO), UNFPA further procured 450,000 vials of subcutaneous DMPA. This easy-to-use injectable contraceptive will benefit over 400,000 women of reproductive age.	UNFPA (2023). UNFPA Kenya Annual Report 2023. (pg5)
UNFPA also worked to **strengthen the capacity of healthcare workers in both public and private sectors** to **increase access to modern Family Planning methods** by training 78 healthcare workers on the effective administration of the hormonal intra-uterine device. A further 12 clinicians from Bungoma and Nairobi City counties were trained on BTL and vasectomy surgical skills. The capacity building contributed **to strengthening access to lesser-used and new methods** including the scale-up of hormonal IUD and DMPA-SC. Through public-private partnerships with the United States International University (USIU) Africa and the Pharmaceutical Society of Kenya (PSK), 27 pharmacy graduates were trained in family planning. The pharmacists will be able to dispense the commodities and counsel and provide services, especially to walk-in clients who seek family planning services in the pharmacies. As a lower middle-income country, Kenya is expected to have a sustainable financing mechanism that supports commodity security and better access to sexual and reproductive health services.	UNFPA (2023). UNFPA Kenya Annual Report 2023. (pg5)
The LMA REPORT (2023) from Kwale and Kilifi included overall supply chain assessment and a "maturity chart" showing relative strengths and weaknesses found.	Kwale & Kilifi Counties Dissemination on LMA Spot Check Findings, and FP SCM Orientation. April 2023; and May 2022 LMA Spot Check report

Assumption 2.2 The Partnership works effectively with national authorities, and other partners, to **expand contraceptive method choice of high-quality SRH commodities** for marginalized groups, in both humanitarian and development settings.



Concerns were noted around stock-outs, poor forecasting, storage and human resource inadequacies.
Similarly, the 2022 LMA spot check report found inadequate traceability of products (bin cards/records gaps), stock-outs, storage problems and expiries, missing/lost commodities and falsified delivery slips, and other challenges.

Assumption 2.3 The Partnership, with the support of the Humanitarian Office, procures, packages and delivers **emergency reproductive health/family planning kits and individual products** with the appropriate range, quantity and quality reaching populations in a timely way at the start of and during humanitarian crises, to enable those affected to meet their reproductive health/family planning requirements.

Indicators

2.3.1 Extent to which **clear roles and responsibilities are established between the Partnership and the Humanitarian Response Division** at the global, regional and national levels to ensure Partnership countries at a higher risk of rapid onset emergencies integrate humanitarian principles (e.g. basic humanitarian functions integrated into the supply framework) to strengthen preparedness and resilience.

2.3.2 Programme **humanitarian response plans** include explicit matching of content of emergency Reproductive health and family kits with identified needs of women and girls in the specific humanitarian setting, in concert with the Humanitarian Response Division.

2.3.3 In **humanitarian settings, the Partnership engages with national authorities** to ensure that its support (including emergency kits) is targeted to all women and girls at risk, including the poor and marginalized.

2.3.4 Those involved in service delivery report products were appropriate, of high quality and delivered in a timely manner during humanitarian crises.

2.3.5 Extent to which at-risk women and girls report access to needed, appropriate and quality reproductive health/family planning commodities and products.

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OBSERVATIONS	**SOURCES OF EVIDENCE**
Humanitarian: There are refugee camps in some counties in Kenya. There was a humanitarian assessment review on PAC and family planning done recently (reporting coming out soon). MSI-K will learn a lot from this on access to SRH in these humanitarian settings. Kenya Red Cross and UNHCR have clinics in the camps and serve refugees and the host communities with health care, but not usually family planning. MSI works with the disaster risk management team to help get commodities.	KII with MSI-K. November 2024
UNFPA works with Implementing partner the **Kenya Red Cross society** in procurement of some commodities in the Reproductive health (RH) Kits (11-12 different ones) for response in emergency areas and hard to reach counties (ASAL counties, refugee camps, as well as in Nairobi flood zones during recent flood disasters). Red Cross has dignity kits for girls, Mama kits and others with support from UNFPA. Their RH kits (e.g. #4) contain oral contraceptives, injectables and implants as well as condoms. Red Cross normally receives and handles kits #1-5, which are different from the dignity kits. The **procurement is done directly by UNFPA, and the warehousing and distribution is done by the Kenya Red Cross Society**. The Red Cross society has a national warehouse + eight warehouses across the country. The organization also has Hubs in ASAL areas, for prepositioning of supplies. They own an internal fleet of approximately 160 vehicles of different sizes/types, which include six specialized trucks for flood areas and hard terrain (for the most remote areas). The RH Kits are procured when there is a **humanitarian need (they are emergency driven**). The Red Cross is the only entity in Kenya to have the specialized trucks for flood zones. They have a **unique humanitarian supply chain with end-to-end services**. The Red Cross has its own fully independent procurement, warehousing and distribution to the last mile. Although the Red Cross's system is not yet integrated with KEMSA's iLMIS system (and Red Cross do not input data into the iLMIS), the latter does record, track and trace Red Cross products, and UNFPA tracker (QSR - quarterly stock report) also tracks the kits, etc. handled by Red Cross. The new tool includes a column for Red Cross products. Red Cross sometimes shares products with other (Government) sites/facilities if needed (but Government does not pay Red Cross for these). They do have **some supply chain disruptions**, especially with **clearance process here in Kenya**. The regulator (Pharmacy and Poisons Board - PPB) has very strict policies around remaining shelf life (and expiry dates) on health products, requiring 10-12 months of shelf life remaining to allow a product to enter the country. (PPB just tightened their rules this year). They also have strict documentation requirements and want to see documents on each item in each kit. This is especially strict for pharmaceutical products. Non-medical items take much less time to clear. Discussions are ongoing with PPB (as well as Kenya Bureau of Standards), and Red Cross does have a direct line/communication with them. Red Cross has also brought UNFPA into the discussion, so that UNFPA also understands the complexities and role of clearing agent (whose KPI is 7 days to clear), as this requires a multi-agency response. Red Cross complies with PPB regulations. If the Red Cross has all documentation in order, the shipments can move. If they get a donation approval for a whole shipment, things can move quickly (e.g. for a disaster situation).	KII with Red Cross Society. November 2024

Assumption 2.3 The Partnership, with the support of the Humanitarian Office, procures, packages and delivers **emergency reproductive health/family planning kits and individual products** with the appropriate range, quantity and quality reaching populations in a timely way at the start of and during humanitarian crises, to enable those affected to meet their reproductive health/family planning requirements.	
Most of the kit contents (family planning commodities, etc) are already registered in the country. Pharmaceuticals must be registered, although there is a waiver process for urgently needed medicines. For some products, there must be a no objection letter from the MoH, and the sole distributor has to certify there is no conflict. They also have to provide the manufacturing authorization and other docs. 1 item without all the proper paperwork can delay the whole kit. So many sectors are involved. Red Cross are zero-rated for customs tax on items they import. Kenya Revenue Authority comes in at the start and end of the process. RC have to show a gift certificate to prove a shipment is a donation (UNFPA does provide this), so that no tax must be paid on it. The **lead time for the kits is an issue** (and they are currently struggling to clear RH kits #4 due to expiry dates of less than 10 months remaining (which is against PPB rules). Red Cross **wishes that UNFPA would start the process and documentation early for any planned items to be donated** (to get started on the process, paperwork, clearance planning). Now items arrive in Kenya and face clearance, PPB and other delays. Red Cross have not been involved in the SP's LMA assessments in Kenya, which mainly involve KEMSA. But they were involved in the audit. **UNFPA has supported the development of reporting tools**, including an App and a manual. UNFPA supported the **development of the Minimum Initial Services Package (MISP)** working with the Kenya Red Cross society. **Capacity building efforts have been extended to community health promoters**, though this is not as technical as trainings for health workers.	
The Government of Kenya has recognised the importance of ensuring continuation of family planning services when disasters and humanitarian crises strike. Continuation of family planning services requires availability of family planning products and technologies in humanitarian settings. **Kenya Red Cross has worked in partnership with the UNFPA to stock RH kits as part of the MISP for use at the immediate onset of a humanitarian crisis.** An assessment of the RHCS Strategy, 2013–2017 identified several challenges with continuation of family planning services in humanitarian settings, including the lack of MISP-trained providers and a failure to prioritise SRH needs.	Kenya MoH, Division of Reproductive and Maternal Health (2020). National Reproductive Health/Family Planning Commodity Security Strategy, 2020/21-2024/25. (pg10)

Assumption 2.3 The Partnership, with the support of the Humanitarian Office, procures, packages and delivers **emergency reproductive health/family planning kits and individual products** with the appropriate range, quantity and quality reaching populations in a timely way at the start of and during humanitarian crises, to enable those affected to meet their reproductive health/family planning requirements.	
Key accomplishments in 2022 through UNFPA Supplies Partnership support: -Increasing access to family planning in humanitarian settings -The Integrated family planning LMIS has included the monitoring of IARH kits supplied under humanitarian settings. The system is collecting the consumption data for purposes of resupply and staging at the strategic hubs backed by data. The reporting tools for the health facilities are aligned to the LMIS to cover these commodities. In addition, the LMIS has collapsed multiple supply pipelines into one to monitor consumption and ensure resupply is based on actual consumption. The multiple pipelines are a recipe for overstocking, expiries, damages and pilferage.	UNFPA (2023). Kenya Country Narrative Report 2022. (pg2)
Humanitarian action • With support from the UN Central Emergency Response Fund (CERF), a rapid response grant and funding from the Government of Japan, UNFPA and its partners worked to deliver integrated life-saving sexual and reproductive health and gender-based violence services to mitigate the effects of the drought and flood emergencies in Turkana, Wajir, Mandera, Tana River, Isiolo, Samburu, Garissa, and Marsabit counties in Kenya. This was achieved through integrated health outreaches to deliver quality reproductive, maternal, and newborn health services, that included family planning information and services. • A total of 1,160 health care professionals and targeted frontline workers were trained in the clinical management of rape (CMR) and MISP for reproductive health in emergencies. These included 27 county sexual and reproductive health coordinators who received ToTs capacity building on MISP, and 23 service providers trained as CMR ToTs. Key results: • 310,669 people reached with Family Planning Services in UNFPA-supported facilities	UNFPA (2023). UNFPA Kenya Annual Report 2023. (pg12)

Assumption 2.4 The Partnership has demonstrated **adaptability for the effective distribution of routine commodities and NLU products, across different contexts** and through different funding mechanisms, recognizing, monitoring, and consistently mitigating against emerging threats and risks.
Indicators **2.4.1** Documented changes in annual workplans, distribution and supply plans, and allocations of the Partnership commodity budgets at the national level in response to changing conditions/needs, including humanitarian emergencies. **2.4.2** Documented examples of programmes/project/policy design changes including mitigating measures to address challenges to NLUs including: ● engaging a single manufacturer ● addressing registration/waiver issues ● taking proven (piloted) solutions to scale. **2.4.3** Documentation on mitigation measures against challenges for NLUs – demand generation; capacity building; single manufacturer; registration / waiver issues; moving from pilot to scale-up. **2.4.4** Existence of analysis and systematic processes for applying different funding mechanisms (match funding, routine funding, NLU commodities, emergency Reproductive health commodities kits) effectively to different contexts, i.e. analysis reports, fund applications).

Assumption 2.4 The Partnership has demonstrated **adaptability for the effective distribution of routine commodities and NLU products, across different contexts** and through different funding mechanisms, recognizing, monitoring, and consistently mitigating against emerging threats and risks.	
2.4.5 National reproductive health/family planning plans, strategies and programmes include measures to address and resolve barriers to access for poor and marginalized women including: • Geographic access • Price and affordability constraints • Timely delivery and stable supply • Choice of methods • Harmful social norms limiting access. **2.4.6** Views of UNFPA country office staff, national health (and emergency response) authorities, multilateral and bilateral partners on the availability of a range of high-quality reproductive health/family planning commodities in both development and humanitarian settings.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
The Kenya Red Cross Society is a key partner of UNFPA SP for **humanitarian settings** (ASAL remote areas, refugee camps, hard-to-reach areas, and disaster areas). Red Cross works under the **Humanitarian line on UNFPA budget and workplan**. Red Cross has monthly and quarterly meetings with UNFPA (Humanitarian officer of long standing), and discuss RH/FP commodities with Charity at Country Office. Since 2021, Red Cross feels that there is better programmatic and implementation coordination with UNFPA and the Partnership. There are always discussions and ways to further improve the implementation.	KII with Red Cross Society. November 2024
Outreach, distributions and support to **humanitarian areas and most remote locations (e.g. ASAL region), as well as marginalized groups** is done by various partners to UNFPA including MSI-Kenya (Asal), Kenya Human Rights Commission (access and human rights & legal support), This Ability Trust (access for persons with disabilities), Polycom Girls (girls/youth in slum area), NAYA (youth), ICRH and others.	KIIs with MSI, Kenya Human Rights Commission, This Ability Trust, Polycom, NAYA, ICRH, UNFPA CO

EVALUATION QUESTION 3: To what extent is the Partnership effective at ensuring that **reproductive health commodities reach the "last mile" and promote harmonization and integration of supply chain systems in countries** for all women who want and need them, including marginalized groups and those in humanitarian situations?					
CRITERIA	Effectiveness/ coverage	**AREA OF INTEREST**	Strategic objective 2 – Strengthened Supply Chains Ensure supplies for reproductive health commodities reach the "last mile" and promote harmonization and	**LINKAGES TO THE THEORY OF CHANGE**	Linked to the green boxes for strategic objective 2 in the middle of the theory of change

			integration of supply systems in countries		
RATIONALE	This evaluation question focuses on assessing the **contribution made to the achievement of strategic objective 2, which aims at ensuring that reproductive health commodities reach the "last mile" while promoting improved functionality and tracking within supply systems in countries.** This question focuses on assessing the needs for supply chain strengthening to improve availability of reproductive health commodities, addressing these needs, improving data visibility for better data-driven decision making and supplies management, and reaching service providers and end users at the "last mile", including in humanitarian and fragile or conflict settings. Following the logic set up in the reconstructed theory of change, this question mainly focuses on modes of engagement of (a) technical assistance, (b) capacity building, (c) service delivery, and (d) evidence generation and dissemination. Additionally, since this question focuses on access to reproductive health commodities, it will also address the criteria of coverage linked to humanitarian actions, which addresses the extent to which population groups facing life-threatening conditions were reached by humanitarian action.				

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Indicators **3.1.1** Mechanisms for joint assessment (with partners) of national supply chains and identification of gaps and weaknesses are operational. **3.1.2** The Partnership initiatives to strengthen SCM are targeted to addressing agreed weaknesses. **3.1.3** The Partnership support to strengthening SCM contributes to but does not overlap or duplicate support from other bilateral or multilateral partners or national programmes. **3.1.4** Views/experiences of national supply partners on the adequacy of the identification of needs toward strengthening the SCM and systems.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
Innovations of the SP include the iLMIS system, rationalized ordering by health facilities, better stock management; as well as better coordination among donors/partners, working together to enhance last mile delivery and access.	KII with CHAI. October 2024
As a partner in the SP, NAYA has **participated in Last Mile Assurance (LMAs) assessments** to confirm the delivery of family planning commodities to hard-to-reach health facilities. Access for youth is hampered at different levels. Government has the largest health facility network in the country, but not all are youth friendly. In urban areas, youth know where to go (word spreads), and they find youth-friendly spaces (e.g. at Kenyatta Hospital). UNFPA, UNICEF and other partners help with getting the word out to the youth. But rural youth are not so well connected.	KII with NAYA. October 2024
KEMSA is the Government agency (actually an "authority"), acting as procurement agency of the Government. They are part of the Partnership for FP supplies. **UNFPA and partners worked with KEMSA to develop the system (iLMIS) to track family planning commodities**. They agree on activities, and NCPD supports KEMSA with procurement. The funds for procurement of FP commodities by KEMSA comes through NCPD. The iLMIS is integrated, because the KHIS (patient/consumption data) is matched	KII with NCPD. October 2024

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to the LMIS (logistics management info system). The iLMIS is fully functional now, but some counties have not yet been trained. **KEMSA has a central stores and delivers quarterly directly to the health facilities on a "pull" system (based on orders**). Counties no longer keep stocks of commodities in central county stores; **KEMSA delivers directly to the health facilities**. FP goods are delivered with essential health products. There are not big stock-out problems now. The iLMIS reports on monthly orders and consumption.	
County health offices are continuing to be **trained on the iLMIS**. However, **county staff turnovers are a threat** to the gains made in training staff in iLMIS. **Data audits are being planned in the near future (UNFPA and NCPD are involved**), to verify data accuracy/quality. National Treasury provides a tax exemption for the commodities coming from UNFPA. This is now digitized, more streamlined. Commodities used to get stuck in the port, but this is resolved now. There is **an LMA audit each year, to see that commodities are reaching the last mile**. They try to make sure the commodities reach the health facilities (and ask counties what they are doing, what is happening – since the health sector devolved in 2013, counties are more autonomous).	KII with NCPD. October 2024
They (FCDO) **join UNFPA for field visits** (e.g. last mile assurance visits) to ensure products are reaching the facilities and communities. The Director General (DG) of NCPD found stock-outs at the last mile. It was discovered that the country only has about six months' of stock of family planning commodities now (too low), due to stock/supply chain management and funding challenges. **UNFPA helps with LMA, LMIS and product visibility. UNFPA should build on the HSS efforts to help trace commodities to the last mile**.	KII with FCDO. October 2024
The **SP has been supporting the distribution and logistics management of family planning commodities**. Distribution is done by Government (KEMSA), and Government is given funding for this. UNFPA and USAID do their own procurement. The **SP facilitated the innovation of the LMIS for managing the supply chain of family planning commodities**. The LMIS enhances data availability which is important to support decision-making such as strengthening of interventions, identification of gaps, understanding their underlying causes to inform the design of interventions. Data is also a strong pillar for smart advocacy	KII with FP2030. October 2024
The **engagement between UNFPA and supply chain managers has mainly been through KEMSA** ensuring that the right capacity and technical assistance is available for the functioning of the iLMIS. **UNFPA has developed training packages and supported ToT workshops** on the iLMIS for supply chain managers and health care providers. **New technologies or innovative practices**? The iLMIS, e-POD, CEAW, new methods (NLUs), scaling up hormonal IUDs, innovations like the LMA and end-to-end visibility are all innovations supported by UNFPA SP. **TA/capacity building to improve SCM abilities** 33 out of 47 counties are able to use the iLMIS. They are able to check the status of commodities in all health facilities in one place and are able to make procurement requests.	KII with ICRH-K. October 2024

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The LMA is useful, but only done in UNFPA-supported counties	
The iLMIS (which SP supported) is an **innovative development**. Working with the VAN (Visibility and Analytics Network) of global supply data, the data is real time and visible. County pharmacists and sub-county pharmacists can see the data in real time. The SP has helped **improve delivery to the last mile through support for iLMIS development, data quality, advocacy, training.**	KII with NCPD. October 2024
UNFPA has supported in navigating bottlenecks with the regulators to facilitate authorization of pharmacists to administer family planning products. They supported the development of the **training of pharmacists to administer FP** (short term methods including DMPA-SC and IM) and provide counselling. **UNFPA mobilized stakeholders** to participate in the review and updating of guidelines including criteria for methods. The **SP-supported iLMIS; is a breakthrough innovation in Kenya**. The iLMIS has facilitated prioritization of commodities and supply chain management to complement service delivery; SCM had been overshadowed by focus on service delivery. Now one can see the status of commodities in real time, even at sites far away from national level. UNFPA convened and coordinated partners towards adoption of the **TMA.** They tied the strategy to the bigger picture of the country's commitment to FP2030, UHC and SDGs. TMA is aimed at support to bridge gaps in commodity availability in the public sector. Jhpiego is part of Technical Working Groups that meet monthly or quarterly: (i) Service delivery (ii)TMA & private sector (iii) supplies and supply chain (iv) Pharmacy. These are mirrored at county (and some sub-county) levels. Professional associations both at the national and subnational levels are also involved. UNFPA supports the national level meetings. **UNFPA are driving the tools, guidelines, TWG plans**. The SP facilitated the innovation of the LMIS for managing the supply chain of family planning commodities. The LMIS enhances data availability which is important to support decision-making such as strengthening of interventions, identification of gaps, their underlying causes to inform the design of interventions. Data is also a strong pillar for SMART advocacy	KII with JHPIEGO. October 2024
MSI used to ship the family planning commodities they used for the facilities they support; however, since 2022, their commodities are no longer tax-exempt. Taxes (15-20%) plus other logistical costs (freight, transport, insurance) are added per shipment, accumulating to very high costs that MSI has to pay, even for donations. MSI have now resorted to **relying on the UNFPA shipped commodities** to manage the costs. MSI used to get commodities from UNFPA, but now get them directly from KEMSA. (MSI submits a stock status report to UNFPA Country Office quarterly). MSI-K's commodities funding comes from UNFPA (70%), USAID (25%), and CHAI (5%). **Availability of family planning products varies** based on demand; COC stocks have been a challenge because of high demand; injectable family planning methods are used by 40-50% of clients in public facilities, so these move fast too. Another item that is often short is the 1-rod implant (which women prefer), so they sometimes get help from USAID to fill gaps in stocks. Male condom stocks have also been a challenge. The shipping in of condoms follows vertical	KII with MSI-K. November 2024

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programmes: Global Fund ships condoms in specifically for HIV prevention (so they cannot be shared) therefore condom programmes in facilities are well-stocked; but **UNFPA-supported family planning condom supplies have been experiencing stock-outs.**	
Through the Supplies Partnership, UNFPA has **engaged with national supply chain managers by supporting capacity development efforts for managers at both national and county levels. UNFPA has also been an active member of the National and County Order Management Teams.** UNFPA participation in the Order Management Teams fosters **collaboration and coordination**, helping **streamline processes** and **engage other partners** in supporting the iLMIS. The investment in the iLMIS by UNFPA has had a **catalytic effect** on other partners who wish to invest in the system for other products such as for HIV, TB etc. In collaboration with other partners, a staged approach which includes a roadmap, and tools have been developed. Through the Supplies Partnership, there have been some **efforts to ensure reduced stockouts of family planning commodities** with the engagement of various IPs supported by UNFPA such as GAVI, InSupply, CHAI, Marie Stopes and others. Before 2021, there was no system, just monthly reports on stocks. **Now supply management has improved with the iLMIS, quarterly stock reviews, monthly consumption reports**. The Global VAN (visibility analytics network) shows stocks at global level as well as sources of funding. **UNFPA provided technical assistance to KEMSA during the development of the iLMIS**. UNFPA through the supplies partnership has also supported the **development of training packages** for national, county and sub-county health officials on the use of the iLMIS and how to interpret information in the commodity early warning and alert system, to inform order management. (Most sub-counties have electricity and connectivity, so can use the system, but some remote facilities do not). Does the Partnership help introduce **new technologies or innovative practices**? Yes, through the support of the Supplies Partnership, **new technologies have been introduced**. Apart from the iLMIS and the Electronic Proof of Delivery (e-POD), the interaction with the VAN has been a game changer in terms of access to global supply data, the data is real time and visible. County pharmacists and sub-county pharmacists can see the data in real time. To what extent has the **TA/capacity building provided improved Kenya's country's SCM abilities?** The TA particularly towards the development of the iLMIS has helped expand the capacities for SCM not only for family planning commodities but also for other commodities relating to HIV, TB etc. KEMSA reports positive trends in reporting rates, stock-out rates, validation checks with the use of the system. Condoms, combined oral contraceptive pills are above desired stock rates, and some other products still have stock challenges. **Under the**	KII with KEMSA. October 2024

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Supplies Partnership, products sometimes come in to supplement their stocks, to avoid stock-outs. Health facilities often do their own re-allocations with the help of Implementing partners, under the County management team. InSupply, CHAI, MSI and other SP partners all assist. Under the SP, there have been **four LMA assessments done so far** (the latest one month ago). These are a good way to see gaps, and to target on-site mentoring, gap-filling and needed efforts at struggling HFs. The SRAT informs about the gaps found in the assessment. Under the LMA process, KEMSA must account for each product, and commit to GSP (good storage practices) and GDP (good distribution practices). With UNFPA support and MoH, they have **trained ~2800 people so far**, and plan to train HIV/TB/Malaria programme people on the system soon. KEMSA conducts trainings at county level. Many HFs still use manual/paper record keeping systems. The health records officer at sub-county level then enters the manual data into the KMIS, then KEMSA integrates into the iLMIS. Each block of the country orders at a different, designated time. Distribution is then done monthly (by KEMSA, to HF level) with MoH authorization. **KEMSA serves all HFs, including in refugee camps** (of which there are several in Kenya, including two longstanding ones in the north). KEMSA reaches the last mile using their own fleet (25+ trucks) and outsourced delivery services (70% of their deliveries). Their allocation system uses AI to inform distributions.	
UNFPA funds MSI to **support LMA activities** in Narok, Isiolo, Nairobi and Bungoma. They train health facility workers on commodity management: quantification and forecasting through proper entries into the bin cards; and on ordering commodities. They support them to address gaps identified in LMA assessments. This facility-based TA is supported by UNFPA. (There is so much movement of personnel in public health facilities, there is constant turnover, and constant need for training and task sharing.) UNFPA supported MSI to disseminate LMA assessment findings to the leadership in Nyamira and Narok counties and follow up on progress made. MSI supports re-distribution of family planning commodities between facilities as part of rationalization of stocks; part of it is supported by UNFPA – re-distribution of commodities during the quality-of-care supportive supervision visits to the health facilities (commodity management, service delivery). MSI are also members of the NOMT and participate in commodity rationalization. They conduct supportive supervision activities with KEMSA and county pharmacists to support commodity re-distribution activities in between health facilities.	KII with MSI-K. November 2024

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They also support 205 health facilities in quality of care to become centres of excellence; they provide **mentorship in family planning, PHC, service delivery and reporting of commodities.** They **train them in order for them to cascade** the knowledge and skills to other facilities in their counties. **Reporting has been the biggest challenge**. Many HFs still use manual/paper records, but most Level 4 and 5 facilities (hospitals) are now using the iLMIS.	
In Supply are a Collaborator with UNFPA SP. They are part of TWGs, and the National Order Management Team (NOMT), which helps to coordinate. The LMA assessments look at HF level, last mile in the chain. Why doesn't the **assessment look at the macro level too (the funds flow to get the products)? Look upstream at MoH/MoF money flows. LMA (last mile) cannot happen without the upstream!** **<u>Capacity building and TA:</u>** SP had supported Kenya to sign up as a member of the Global Family Planning VAN which enhances capacities for quantification and forecasting to optimize the supply chain. The data that feeds into the VAN is from the iLMIS and UNFPA data. InSupply are also members of the consensus planning group (CPG), an advisory group which provides guidance on what a country should get based in alignment with its plan. Also participate in commodity security monitoring Heavy investments have gone into KEMSA to improve the accountability of the SCM systems; it is an ongoing process. Reliance by KEMSA on the government funding to meet the operational costs is a challenge due to funding gaps. **<u>Innovation:</u>** In Supply works with the SP to promote authorization of private sector pharmacists to administer family planning commodities e.g., DMPA-SC. The aim is to enhance access to family planning commodities. SP works with InSupply to identify the requirements to be met which will facilitate availability of family planning products within private pharmacies in collaboration with the regulators with regard to infrastructure, competencies, environment etc. **<u>Specific contributions or added value of the SP in ensuring that adolescent SRH commodities reach end users</u>** Using data on teenage pregnancies and maternal mortality among teen mothers to advocate to decision-makers opposed to ASRH Integrating counselling of adolescents and young mothers into provision of ASRH to enhance life skills SP has supported development and roll out of the self-care guidelines which have faced opposition due to the inclusion of post-abortion-care (PAC). UNFPA have also supported in navigating the bureaucratic bottlenecks. Five Counties have received training in the self-care guidelines.	KII with In Supply. October 2024

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There were gaps in the SCM; and erratic ordering from the counties. Lack of visibility of orders from the counties, and commodities movement along the supply pipeline; no systematic way for tracking orders and commodities. KEMSA is the main national distributor of government-supplied family planning commodities; is free to the counties, but KEMSA has operational and logistics costs. It is more economical when KEMSA transports together with other medical commodities, however counties opted to source medical commodities locally making transportation of family planning commodities uneconomical. Agreement arrived at that counties will order through KEMSA to facilitate economical transportation of family planning to the facilities **Capacity building:** The LMA and Supply chain TA work under the SP is mainly at KEMSA. Heavy investments have gone into KEMSA to improve the accountability of the SCM systems; it is an ongoing process. Reliance by KEMSA on government funding to meet their operational costs is a challenge due to funding gaps. KEMSA is in transition, looking at their own fundraising and systems strengthening. They have undergone restructuring to be made fit for purpose and were "grossly overstaffed" before. A challenge is that KEMSA cannot commit to volumes/orders with manufacturers (whereas UNFPA can, to its suppliers), so KEMSA is more challenged to procure efficiently **Innovations**: The iLMIS (with UNFPA support) has been a "game changer," and revolutionized SCM for family planning commodities; enhanced access to commodities because orders can be made online. It has leveraged on the widespread internet penetration across the country. Now the whole country "is connected" (donors and Government contribute 10% of the commodities value for distribution). If we can now link up more to the GP VAN, it will help more to see the upstream pipeline of stocks. A challenge is that "big procurement attracts a lot of vested interests". KEMSA had a lot of challenges (and scandals) in the past; it is hoped that the new efforts and new CEO will be better.	KII with Options. October 2024
Partners (including UNFPA SP) are involved in work to assess stock problems in country. USAID was invited to join the teams for NCPD stock taking. USAID works with UNFPA in supporting the family planning iLMIS with KEMSA – although their work with KEMSA was paused. They increased their procurement to USD 4.6M in family planning commodities for this fiscal year. As part of the work to track commodities, USAID is **part of the Commodity Security TWG**, with UNFPA, other partners and MoH, so they can see what stocks are where in the national system. For family planning, they have the LMIS system, so can clearly see the supply and demand (consumption) of family planning products. They are also part of the NOMT USAID **collaborated with UNFPA on the Visibility Analytics System (VAN) for global family planning supplies**. (RHSC: "VAN" captures data from multiple sources to improve what we call "supply chain visibility". The VAN offers our community a	KII with USAID. November 2024

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platform to assess supply needs, prioritize them, and act when supply imbalances loom." https://www.rhsupplies.org/gfpvan/about.html) (It was not clear what USAID and UNFPA did to bring the VAN to Kenya? Or to ensure KEMSA/others were accessing VAN data?) **Capacity building**: UNFPA SP Partners are providing capacity building support in supply chain management, forecasting. Key Performance Indicators (KPIs) include stock-out days (with DMPA as a tracer commodity)	
The iLMIS for commodity management operates from the level of the sub-County hospital. (The Health Centre sends their paper forms to the sub-county team to enter into the LMIS system). At this Health Centre (L3) and lower levels of care, including the community, the commodities' documentation is done manually using paper-based records. The CHPs also keep paper records. The sub-county orders from KEMSA, which delivers every three months, but **recently there are delays**. The CHPs reported that the FP supplies have been good in recent years; they usually get five boxes of condoms each month. However, others said the **supply situation has been "50/50" lately**, and in the 2 weeks preceding the visit they had experienced a **shortage in the supply of condoms for distribution, and the health facility was stocked out of most family planning methods**. They also reported that their household clients had reported stock outs at the facility	KII with Nairobi County Kibera city – Kibra Dispensary –staff, beneficiaries, CHPs. November 2024
Meeting with Pharmacist and RHC coordinator and clinical officer in charge **Stocks have been a challenge** – e.g. Jadelle, Depo IM and Depo SC self-injection, NXT, and male condoms are stocked out (condoms for 5 months already). They have been getting some items redistributed from other health facilities in the sub-county. There are 25 HFs (but one is St Elizabeth – Catholic – so does not do FP). They receive quarterly deliveries from KEMSA, often in combined loads (e.g. ART and family planning products together). The health facilities are not monitoring their stocks enough – the **DMPA (~3 yr shelf life) came before the trainings could happen, so it expired** as it was not able to be administered. There is **bias/preference in the community** – e.g. women prefer the 1-rod (NXT) 3-yr implant to the 2-rod (Levoplant), so the former runs out while the latter is overstocked. Some complain about side effects with the 2-rod product (but they have the same dosage). There is the older intramuscular injectable Depo, but younger women especially prefer the new self-injectable. Women come for their scheduled appointments, but stocks of the self-injectable are low, and they worry they will not be able to get theirs. This is a **missed opportunity**, when clients are offered a choice of methods, they choose, are trained, and then don't get it (and are either forced to take another method or find it elsewhere). (The next day was to be a busy FP day, when they can expect ~30 women to come). All the HFs (including the main pharmacist at the sub-county hospital) use manual (paper) records, but they would prefer electronic. **Training:** Pharmacist was trained in Nakuru on the iLMIS for three days in Aug 2024. It was good, but they don't have the system here at the sub-county hospital, so she hasn't been able to use her training and run the system here. Another was trained in May	Narok County - Ololulunga sub-county mgmt. and HF visit (and CHPs and FGD with women beneficiaries). Narok county. November 2024

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2024 in Nakuru as ToT in 1 class (five days) for the pharmacy package, so that she can train the private pharmacies/chemists. There are nine sub-counties in Narok County. Out of the hundreds of chemists in the county, only ~25 have been trained so far. Why? Probably due to a lack of funds for the training and to get the commodities. Facilitation funding is lacking. If this training was rolled out more, it could really help build access and reach to more women. Sometimes products (e.g. IUDs) are being supplied to health facilities without the equipment or personnel to handle them. They only receive the IUDs but not the tools/equipment to insert them, so they cannot give these to patients. There are gaps in money, knowledge, equipment, training – if these were addressed, their uptake would rise. Demand generation is happening. There is training of health workers on data management. The **women beneficiaries** reported that they had not experienced stock outs of their FP products of choice during their appointments. The challenge they cited was long queues and long waiting times on their appointment as there was only one nurse attending to them at the clinic. The long waiting times made some of them opt for private pharmacies where they were forced to pay for the services, whereas some would go away to return on another day. Two of those who reported that they had gone away to return another day shared that they had gotten pregnant during this interim period. 2 women reported that they had been able to access the DMPA-SC, but only one was "courageous" to self-inject. 3 doses were dispensed to her, which were documented by the nurse. She also received counselling on how to administer and store the unused doses. She was quite happy with this approach which she said, "saved her time and transport" (money) because she needed to visit the health facility fewer times.	
PSK procured Sayana press through UNFPA. PSK has partnered with UNFPA in LMA assessments in three counties - Isiolo, Meru, Tharaka Nithi **Capacity building:** Through the county management training where PSK is one of the IP supporting these efforts and there have been improvements especially for the pharmacists that get the family planning training. **Innovations:** Yes, the support from UNFPA through the SP has helped introduce the iLMIS and its various modules. Another innovative approach is that of engaging private pharmacists to administer FP. This practice was initiated by the development of the guidelines and training package in collaboration with the Pharmacy and Poisons Board. PSK has been one of IPs rolling out the training package. The only challenge is that the iLMIS training is available to facilities at the county and sub-county levels only. Lower-level facilities still have many challenges with orders and supplies management. There is reliance on mental arithmetic and assumptions as opposed to actual counting because their order management system is still manual. An additional gap at the sub-county level is	KII with PSI-Kenya. October 2024

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that the iLMIS training is not cascaded by those who have been trained to other HCWs. Health facilities in remote areas with limited internet connectivity would have challenges implementing iLMIS. There is an improvement in the service delivery because of the enhanced capacities that have been as a result of the investments from UNFPA. There have been more counties trained in the iLMIS helping to improve the efficiency of the supply chain **<u>Specific SP contributions/value add:</u>** The TMA is a game changer. Working with partners that have social enterprises has helped to ensure that even though there is a shortage of family planning products in the public sector, the private sector is able to step in and provide sustainable and affordable products to adolescents and other end users. PSK distributes Femi Plan and Femi Ject across all 47 counties in Kenya	
The development of the iLMIS; and synergy between the HMIS and the iLMIS is a **great innovation** in Kenya, done with UNFPA SP support/leadership	KII with RHNK. November 2024
<u>SCM support:</u> UNFPA through the SP supported the revision of the Logistics Management Information System (LMIS) tools and order forms. This revision has also helped position UNFPA in the various task forces and teams where information on the key areas of need regarding SCM are identified and shared. Also, through the SP, there have been LMA assessments done in 12 counties and 137 health facilities since 2021 - with FCDO, USAID, MoH, KEMSA, and county governments. After these supply chain capacity assessments, an action plan is developed to address the identified gaps. There is an integrated supply chain training package (including last mile assurance as one module) that was developed under the SP, rolled out with MoH and MSI to increase the capacity of county teams. The Sustainability Readiness Assessment Tool (SRAT) is produced annually (last one was 2023), in collaboration with partners, following the LMA assessments. The LMAs are useful, but they want to expand these to be done in more counties. **Capacity building:** UNFPA through the SP supported the development of the Integrated National SCM ToT training package. **<u>Innovation:</u>** Yes, through the Partnership, new technologies and innovative practices have been introduced. There has been the digitization of family planning Commodities tax exemption tools, the introduction and roll out of the VAN as well as the development of the iLMIS. **<u>Results:</u>**	UNFPA Rep and Key staff meeting October 2024

Assumption 3.1 The Partnership engages with national supply chain managers and other relevant partners in countries to **identify key areas of supply chain management requiring support** and provides evidence-based, targeted capacity building and technical assistance, technology, as well as innovative practices to address the identified gaps.	
As health facilities in the counties and sub-counties are able to use the iLMIS to make orders and record their stock levels, it has made it easier for planning and prioritization at KEMSA. The new iLMIS has helped reduce stockouts and wastage of family planning commodities and decreased Order Turnaround Time (OTAT) from 20 days to 7 days and improved delivery timelines. **Unique contribution of SP:** The support from UNFPA is very advanced and catalytic. The investments made by UNFPA have influenced other partners in the space to engage with the various tools developed in improving supply chains i.e. the iLMIS. For data visibility, UNFPA have made a creative investment with the development and digitization of the integrated National SCM Training Package, the digitization of family planning Commodities Tax Exemption Tool and the introduction of the VAN. The LMIS was largely paid for by the Supplies Partnership since 2021, with trainings in 23 counties and collaboration with other partners (e.g. Chemonics). Only seven counties do not yet have the LMIS functioning. UNICEF and the World Bank are now also using it. **Harmonizing and integrating supply systems** Through the iLMIS, the supply chain has been well integrated and harmonised. Other partners even have an interest in using the new system for products other than family planning commodities. e.g. malaria, HIV TB etc. KEMSA, a parastatal, has a long history and many problems over the years. The system is a “pull” system, reacting to orders from the counties/health facilities. USAID pulled out of working only with KEMSA (due to scandals that took place), and now keep their supplies at MEDS (but this is a Catholic entity, so they do not really handle FP products). It’s a debate among the donors - monopoly at KEMSA, or diversify with a more fragmented supply chain? UNFPA has stayed with KEMSA (although does not have KEMSA procure for them), has invested a lot in KEMSA, and wants to help improve their systems. KEMSA is owed significant arrears of funds from counties that haven’t paid them. FP goods used to be distributed with all other commodities but now they are sent quarterly to health facilities, at particular time of the month. They go with other commodities that are going out at the same time. **Specific contributions or added value of SP:** Through the SP, UNFPA led the development and pilot of a digital tool for health facilities to self-assess on the responsiveness of their services to the unique needs of adolescents and young people. There was also the introduction of the Development Impact Bond, working on catalytic support and not just funding focusing on the availability of family planning commodities for adolescents and HIV. **Reaching last mile:**	

Assumption 3.1 The Partnership engages with national supply chain managers and other relevant partners in countries to **identify key areas of supply chain management requiring support** and provides evidence-based, targeted capacity building and technical assistance, technology, as well as innovative practices to address the identified gaps.	
Humanitarian context: Kenya receives refugees for many years now, from Sudan and many other countries. There are several refugee camps in the country, some operating for 25+ years already (e.g. Kikuma?), with people of many (29+) nationalities living there (Somalis, Yemenis, Afghans, etc) and 70%+ of the residents are female. Kenya also had a severe drought with no rains for 3-4 years, and then massive flooding recently, even in Nairobi. UNFPA has been part of the humanitarian response. Usually, the funding for these efforts comes not from the Supplies Partnership, but from elsewhere (e.g. Japan supplemental budget, other donors). UNFPA Humanitarian Response Division (HRD) is in Geneva (~50 people) and gives minimal support to Kenya. Kenya gets some technical support and other support from HRD regional office in Johannesburg, but the senior humanitarian specialist with HRD sits in Nairobi office with a small team. Kenya, as an LMIC, may get "more support than it should" because of this presence in their offices. Kenya is seen as key for stability in the region, so the US and others do support the country.	

Assumption 3.2 The Partnership, through UNFPA Country Offices and partners, collaborates effectively with country officials and other partners, to develop capacities and skills and to provide technical assistance for the **improvement of the supply chain management systems and procedures**, including LMIS, inventory management, distribution to the "last mile", etc. (Links to theory of change causal assumption 6)	
Indicators **3.2.1** Examples of successful introduction and roll out and adoption of new or improved manual or automated systems for SCM (including LMIS, inventory management and distribution) supported by the Partnership. **3.2.2** Documented efforts to strengthen SCM to address staff capabilities and motivation as well as needed improvements in systems and technology. **3.2.3** Positive findings on training and capacity building outcomes and results reported. **3.2.4** Views of UNFPA country office staff, national health authorities, national supply chain managers and facilities managers at national and sub-national level on quality and usefulness of technical assistance provided by the Partnership. **3.2.5** Examples of how enhanced systems have (or have not) led to improved inventory management, stock-outs, unused inventory, etc.) without duplicating efforts, causing undue delays or expense. **3.2.6** Reported qualifications of supply chain managers and/or levels of vacancy and turnover in SCM over time. **3.2.7** Positive trends in supply chain performance data indicating improved skills and management.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
In partnership with UNFPA, Red Cross have reached over 1,000 health workers in the last year, training them on the MISP (minimum initial service package), and facilitating transport and allowances for these HWs to do outreach outside their health facilities. Red Cross also facilitates - with Government stipends and UNFPA support - Community Health Promoters (CHPs) to work across thematic areas (MCH, family planning, hygiene, etc), and have produced reporting tools for these CHPs as well as an online app for their use. Red Cross has a team for last mile and stock management trainings (e.g. with pharmacists in health facilities).	KII with Red Cross. November 2024

Assumption 3.2 The Partnership, through UNFPA Country Offices and partners, collaborates effectively with country officials and other partners, to develop capacities and skills and to provide technical assistance for the **improvement of the supply chain management systems and procedures**, including LMIS, inventory management, distribution to the "last mile", etc. (Links to theory of change causal assumption 6)	
UNFPA has supported the development of reporting tools by The Red Cross, including an app and a manual	
UNFPA is supporting RHNK on hormonal IUD training, ToT and capacity building of county government pharmacists in the private sector. If their private providers need products, they order them through Government (KEMSA). The iLMIS supported by UNFPA is innovative and effective. RHNK trained county pharmacists on it. It is helpful for monitoring stocks, demand, orders. It has been a big help at NOMT, which uses it for stocks planning. Using the iLMIS, they can see exactly what stocks are where and see which ones may be short-dated and need to be pushed out (redistributed) to avoid expiry. RHNK helps with public-private redistribution, depending on the commodity and what the data shows. They have their own providers and monitor the data on their stock levels to see who is over- or under-supplied. RHNK can do their own distribution through car, van, and courier services. They also have their own LMIS and HMIS, but also have visibility into the iLMIS at KEMSA. **Humanitarian**: In a recent crisis (floods) in Kenya, Nairobi county gave them some DMPAC, and they were able to distribute the product out to some hard-hit areas.	KII with RHNK. November 2024
Humanitarian: SRH kits are procured through the humanitarian grant managed by the humanitarian officer in Country Office). SP provides support for supply chain capacity building for these commodities. Partners assist, Red Cross and others implement. SRH kits are provided through Humanitarian Thematic Fund (HTF). Human Rights Commission also provides support to marginalized groups all over Kenya. UNFPA Supplies Partnership supports supply chain and health worker capacity building in humanitarian areas. There are some linkages between humanitarian efforts and SP (specific grant under SP and the Humanitarian Thematic Fund). Some FP commodities for humanitarian settings are funded by SP (and capacity building support is provided) as part of the MISP, but the Interagency RH Kits (for SRH and GBV) are funded separately.	KII with UNFPA SRH/FP Specialist. November 2024
FP2030 Government commitment questionnaire Section III: Big Win What would you say has been your country's biggest commitment achievement during this reporting cycle? If you were to do a feature story of your progress, what would you highlight? Response: The innovation to **track family planning commodities movement from the warehouse to the specific facilities country wide through a digitized system known as the electronic proof of delivery (ePOD). It has ensured delivery of family planning commodities to the last mile** thus efficiency of the supplies reducing stock-out for commodities available at KEMSA	FP2030 (2024). FP2030 Government Commitment 2023 Update Questionnaire. (pg18)
Electronic Proof of Deliveries (e-POD) App developed with support from UNFPA for last-mile delivery of family planning commodities Mobile application developed to help enhance efficiency and effectiveness in the delivery of family planning commodities and other essential medicines and supplies to health facilities in the country. The mobile app was developed as part of the "the last mile Kenya" programme implemented through a public-private partnership between KEMSA and Coca-Cola Beverage Africa with	UNFPA (2021). e-POD App for last-mile delivery of family planning commodities wins Global Health

Assumption 3.2 The Partnership, through UNFPA Country Offices and partners, collaborates effectively with country officials and other partners, to develop capacities and skills and to provide technical assistance for the **improvement of the supply chain management systems and procedures**, including LMIS, inventory management, distribution to the "last mile", etc. (Links to theory of change causal assumption 6)	
the support of UNFPA. Borrowing from Coca-Cola's expertise and best practices in supply chain management and distribution, the app digitizes data entry at the point of delivery to provide real-time data on the commodities received, their quantities, and time of delivery.	Supply Chain award. https://kenya.unfpa.org/en/news/e-pod-app-last-mile-delivery-family-planning-commodities-wins-global-health-supply-chain-award

Assumption 3.3 The Partnership has contributed to **improved supply chains** and data visibility and has promoted harmonization and integration of supply systems in countries, to ensure a ready supply of SRH commodities reach end users. (Links to theory of change causal assumption 7)	
Indicators **3.3.1** Reported and/or observed improvements in **demand forecasting/quantification** over time in partner countries (i.e. reduced positive or negative gaps in estimated national demand and procured supply). **3.3.2** Reported or observed improvements or deterioration in **distribution levels** from national to regional and district warehouses and, finally, to service delivery points. **3.3.3** Changes in scheduling/availability of services to improve access for women and girls. **3.3.4** Reduction in frequency, duration and severity of **stock-outs** at national and sub-national levels. **3.3.5** Absence or reduction in the frequency and level of over-supply and unused inventory. **3.3.6** Improved data capture and reporting and tracking of commodities from port of entry to end users. **3.3.6** Changes and adjustments/reallocation of procurement and shipment of reproductive health/family planning commodities and products to match changes in demand. **3.3.7** Timeliness of shipment of identified needed commodities and products during **humanitarian crises**. **3.3.8** Views and experiences of UNFPA staff, national health authorities, national medical stores staff service providers and women and girls accessing commodities.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
Red Cross has faced some issues with lead times on RH kits, due to difficult clearance processes and requirements (e.g. registration and documentation of all health products). They work with Pharmacy & Poisons Board (regulator) and UNFPA to help resolve clearance delays. Red Cross has seen better coordination in the last year among partners.	KII with Red Cross. November 2024

Assumption 3.3 The Partnership has contributed to **improved supply chains** and data visibility and has promoted harmonization and integration of supply systems in countries, to ensure a ready supply of SRH commodities reach end users. (Links to theory of change causal assumption 7)	
The Partnership has been able to strengthen the SCM in Kenya through its ability to provide capacity building opportunities for health care practitioners.	KII with UNFPA SRH/FP Specialist. November 2024
In 2023, UNFPA supported the establishment of a TMA task force aimed at improving access to and use of family planning services and products by coordinating all sectors of the market, including public, private, non-profit, and commercial players, to ensure that everyone, regardless of their income level, can access the family planning method of their choice. A draft TMA service delivery model was developed to guide the piloting of the TMA approach in three cities in 2024.	UNFPA (2023). UNFPA Kenya Annual Report 2023. (pg5)
This Ability Trust implements last mile distribution. This is especially in the Arid and semi-arid regions. UNFPA engaged This Ability Trust in the procurement and distribution of the UNFPA-funded dignity kits (starting after Covid in 2020) which were assembled by This Ability Trust using locally procured items (containing soap, panties, pads, slippers, etc) to those in humanitarian contexts (ASAL region). Mama Siri identified the girls to be reached across the counties. UNFPA provided logistical and financial support for this dignity kit drive.	KII with This Ability Trust. November 2024

Assumption 3.4. The Partnership commodities **reach the "last mile"** in Partnership countries, including in humanitarian, conflict, and fragile state settings.	
Indicators **3.4.1.** Global and Partnership data on "last mile" delivery showing percentage of countries that report having, with Partnership support, improved "last mile" delivery through better local distribution and on-time deliveries, avoidance of stock-outs at facility level, and other means. **3.4.2** Developed strategies, adapted to different contexts, to improve "last mile" delivery and assurance using high-quality data and product tracking. **3.4.3** Extent to which SCM and delivery to service delivery points has improved, or continued, across humanitarian/conflict/crisis Partnership countries. **3.4.4** Extent to which available procurement and delivery data indicate products are reaching the "last mile" – the intended end users in Partnership countries - in a timely way. **3.4.5** Views/experiences of UNFPA staff partners and other relevant stakeholders about the LMA approach.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
This Ability Trust is an implementing partner of UNFPA under the Partnership. UNFPA through the SP supported (funding the bulk SMSs/messaging) the HESABIKA (Be counted) programme led by This Ability Trust. Hesabika is a USSD platform that empowers **women and girls living with disabilities** to register, making them visible in national statistics and policy discussions. (The National Council of Persons with Disabilities has a strict process to get registered as a person who use drugs (30,000 now registered on their platform, and people often have trouble getting registered. Once registered, a person receives a certificate and some benefits from the National Council). This way, even in the discussion and planning for SRH services to reach the last mile, women and girls living with disabilities are not left behind. The phone number	KII with This Ability Trust (group interview). November 2024

Assumption 3.4. The Partnership commodities **reach the "last mile"** in Partnership countries, including in humanitarian, conflict, and fragile state settings.	
used to register is then included in the bulk message system (with support from UNFPA). The registrations come mainly from the areas where Mama Siri works. This Ability Trust **implements last mile distribution**. This is especially in the Arid and semi-arid regions. UNFPA engaged This Ability Trust in the procurement and distribution of the UNFPA-funded dignity kits (starting after Covid in 2020) which were assembled by This Ability Trust using locally procured items (containing soap, panties, pads, slippers, etc) to those in humanitarian contexts (ASAL region). Mama Siri identified the girls to be reached across the counties. UNFPA provided logistical and financial support for this dignity kit drive. **Humanitarian contexts**: During emergencies, there is always a gap in supplies availability, never as fast as they want to get them. E.g. during Covid and during the floods, This Ability supported women in counties affected by providing dignity kits and other products. This Ability Trust do the last mile distribution themselves, to distribute the kits. **Capacity building:** Under the Skills programme run by This Ability Trust, there have been capacity building efforts for health care providers on SRH (257 HWs trained so far). There was a partnership with two hospitals to make them Centres of Excellence to handle those with disabilities (1 in Nairobi county, 1 in Narok county). UNFPA funded the IEC and FP material and information (in English and Swahili, with visuals) on family planning, HIV, SRH and GBV with about 1000 copies printed. UNFPA also funded a documentary and virtual trainings to provide knowledge and conduct surveys and wants to build on this with other partners. **Innovation:** This Ability Trust has a programme called Mama Siri, which is a toll free number that is run by women with disabilities and helps women and girls living with disabilities to access referral services for GBV and SRH. It started in 2020 and since then over 27,000 women have benefitted from the referral services provided. Through Mama Siri, a referral database has been built. Every case is recorded and a follow up system is in place.	
Kenya Red Cross Society is a **key IP to UNFPA for reaching the last mile to remote and disaster areas**, and into refugee camps. UNFPA has supported the Kenya Red Cross society in its procurement of some commodities in the Reproductive health (RH) Kits (11-12 different ones) for response in emergency areas and hard to reach counties (ASAL counties, refugee camps, as well as in Nairobi flood zones during recent flood disasters). They normally receive and handle kits #1-5. It is important to note that these kits are different from the dignity kits. The procurement is done directly by UNFPA, and the warehousing and distribution is done by the Kenya Red Cross Society. The Red Cross society has a national warehouse and eight warehouses across the country. The organization also has hubs in ASAL areas, for prepositioning of supplies. They own an internal fleet of ~160 vehicles of different sizes/types, which include six specialized trucks for flood areas and hard terrain (for those hard-to-reach areas). The RH kits are procured when there is a humanitarian need (they are emergency driven). The Red Cross is	KII with Red Cross. November 2024

Assumption 3.4. The Partnership commodities **reach the "last mile"** in Partnership countries, including in humanitarian, conflict, and fragile state settings.	
the only entity in Kenya to have the specialized trucks for flood zones. They have a **unique humanitarian supply chain with end-to-end services**. Red Cross has its own fully independent procurement, warehousing and distribution to the last mile. Although the Red Cross's system is not yet integrated with KEMSA's iLMIS system (and Red Cross do not input data into the iLMIS), the latter does record, track and trace Red Cross products, and UNFPA tracker (QSR - quarterly stock report) also tracks the kits, etc. handled by Red Cross. The new tool includes a column for Red Cross products. Red Cross sometimes shares products with other (Government) sites/facilities if needed (but Government does not pay Red Cross for these).	
The iLMIS has been a great addition, but the data coming from the health facilities (manual record keeping) remains a challenge. Data quality from these sites remains a gap. There is a **need for more data quality efforts, and to cascade the LMIS to more health facility level site**s, and the e-LMIS system down to CHPs/CBDs at community level.	KII with UNFPA CO SRH/FP specialist. November 2024
Regional disparity in utilization of family planning services demonstrates the level of **inequity in access** - the counties in the Arid and Semi-Arid Lands (ASAL) have very low uptake of family planning - i.e. Contraceptive Prevalence Rate (CPR) as low as 2% in Mandera and Wajir Counties. On the contrary, women and girls in central parts of Kenya, like Nyeri County have higher CPR of 81%. There is also disparity in the uptake for family planning services in different populations. The unmet need for family planning is higher among the unmarried women and adolescents at 19%; while those living with HIV have an even higher gap of 36%. Reported barriers to the uptake of modern family planning methods in Kenya include lack of commodity security, perceived side effects, high costs of financial access to family planning, failure of some family planning methods, peer influence, gender-based violence as a result of conflicts in families, overuse of contraception, health system challenges, and preference for traditional family planning methods.	UK Foreign, Commonwealth & Development Office (2023). Concept note: Accelerating the achievement of Reproductive Health Commodity Security in Kenya. (pg2)

EVALUATION QUESTION 4: To what extent is the Partnership contributing to **strengthening an enabling environment** where governments take up the responsibility of providing choice to quality reproductive health commodities to those who want or need it?					
CRITERIA	Sustainability	**AREA OF INTEREST**	Strategic objective 3 – Enabling environment dimension	**LINKAGES TO THE THEORY OF CHANGE**	Linked to the yellow box on the right of the theory of change representing the enabling environment dimension.
RATIONALE	This question focuses on **assessing the contribution to strategic objective 3, which aims to increase and diversify countries´ financial and programmatic contributions to reproductive health** as a core element of sustainable development. It aims to examine whether adequate conditions are implemented to maximise the sustainability of Partnership results. Following the theory of change, this is achieved mainly through advocacy and evidence-generation activities to promote and achieve government ownership of reproductive health supplies, including last-mile assurance and reaching those most left behind.				

	Specifically, this includes the Partnership contribution to increased and diversified programmatic domestic financing for reproductive health, as well as the contribution to increasing and formalizing political commitment towards strengthening reproductive health and the health system in general. The question also examines the financing structure and tools of the Partnership itself to determine how well they support the increased sustainability of RHCS by promoting the achievement and measurement of increased political and financial commitment from targeted countries.

Assumption 4.1 The Partnership, through UNFPA Country Offices and partners, effectively supports national authorities to significantly **increase and diversify programmatic financial contributions, as well as to prioritize reproductive health** as a core element of sustainable development by governments.	
Indicators **4.1.1.** Percent of targeted countries where governments have increased domestic financial resources to reproductive health commodities. **4.1.2** Percent of Partnership countries where there is evidence of diversified funds for reproductive health commodities. **4.1.3** Trends in allocation of reproductive health/family planning budgetary lines in targeted countries. **4.1.4** Evolution of the external support of reproductive health/family planning received by targeted countries (including UNFPA and other sources). **4.1.5**. Processes in place to verify governments' effective purchase of committed commodities. **4.1.6** Perceptions of stakeholders, including national health authorities and other partners, expressing confidence in the contribution of the Partnership to the prioritization of reproductive health in Partnership countries. **4.1.7** Views of UNFPA staff and other Partnership stakeholders at national level on context-specific strategies to implement funding to financing measures for RHCS.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
Through advocacy of NCPD and leadership of UNFPA with partners, the MoH **signed the Compact and committed to co-financing** (in increasing increments) the SP products over 3 years. The PS of the MoH has become an advocate and champion of family planning and drives the commitment at MoH (as well as the DG). They are trying to build more family planning champions. Advocacy (with UNFPA support) is ongoing.	KII with NCPD. October 2024
The Partnership has advocated, and the MoH has participated in the **development of the national family planning policy** which is almost finalized; but has been halted by the legal action taken against it due to the clause permitting access to family planning commodities for adolescents.	KII with NAYA. October 2024
UNFPA has supported NAYA to conduct **advocacy for the national government to comply** with the ICPD 25 commitments	KII with NAYA. October 2024
CHAI has worked with SP and other partners in country to **advocate for Government contribution and commitment**. CHAI did this with the World Bank Global Financing Facility (GFF) too. Before 2016, the donors weren't really talking to each other or coordinating well. Then 2016-2018, there started to be problems in the system, and the Government knew how to manage (manipulate) the donors. This forced donors to work together, with a united front in dealing with Government. They made some progress, although there were some disruptions with Government	KII with CHAI. October 2024

Assumption 4.1 The Partnership, through UNFPA Country Offices and partners, effectively supports national authorities to significantly **increase and diversify programmatic financial contributions, as well as to prioritize reproductive health** as a core element of sustainable development by governments.	
They have been working with the Partners to **lobby for inclusion of family planning in social insurance**. Around family planning, partners including UNFPA are "making a lot of noise" and lobbying. But when a financial crunch comes (as now), FP can fall away as other programmes are seen as more urgent. Supplementary budgets come through with changes, and cuts. (E.g. in June 2024, the Budget was read, and angry protests erupted in the streets ("Gen Z protests" – at which many people were injured a died). There were many cuts, taxes, and fees in this new budget. It is up to the MoH to prioritize their allocations, when they get their funding from Treasury. So there is much jostling and lobbying within MoH to secure funding for particular programmes. Funding is released from Treasury based on liquidity, so it may be released in two batches during the year (and line items within MoH budget allocations are often ignored). MoH departments have to start lobbying early, before the new financial year begins in July.	
MSI have been **advocating with members of the Parliamentary health committee** and have secured some champions (although it's a "mix", with some pro-choice, others anti-choice). It's an ongoing effort, in different forums. (Most of Parliament are men, and most are not pro-choice). They have experienced **challenges with the members of the legislative budget committee** who prioritize allocation of funds to the constituency development fund (CDF) to gain political mileage at the expense of family planning. (Each MP controls the CDF funds and decides what to fund in the county). MSI and other partners are working with NCPD to carry out advocacy at both the national and subnational levels, and are making some progress.	KII with MSI-K. November 2024
UNFPA has been trying to **push the Government to own the agenda and process of family planning**. In the last two years, the donor trying to "awaken the sleeping beast" is UNFPA. UNFPA has been leading the effort. USAID has "gone quiet", FCDO is shifting programme priorities (DESIP programme ending); and BMGF has said they will no longer fund FP commodities. So, Kenya may be left with only UNFPA and USAID in the FP space. As a Collaborator to the SP, FP2030 has been advocating with governments all over the region to honour their commitments to the Compact and also pursue sustainable financing options for family planning commodities. The Compact is good but did not take the country context into account; it did not recognize the pre-existing MoU regarding government contributions towards health (the counterpart funding). Through the compact MoH is allocating money, but money is seen to be leaving the government to go to the United Nations. This is seen to be reverting to a 'partner-led approach.' The changeover of political leadership destabilized the process of establishing ownership due to unclear prioritization of the agenda for family planning. The PS has agreed to be an family planning champion to support the technical RMNCAH team to advocate for resources. But there is limited passion/interest from the RMNCAH technical team to follow up with Treasury on the money allocated. They were not present at the 2022 and 2023 budgetary allocation meetings with the finance team; and this led to budget cuts for their department (SRH/FP). There is low prioritization of the implementation of the Compact within MoH RMNCAH technical team.	KII with FP2030. October 2024

Assumption 4.1 The Partnership, through UNFPA Country Offices and partners, effectively supports national authorities to significantly **increase and diversify programmatic financial contributions, as well as to prioritize reproductive health** as a core element of sustainable development by governments.	
Advocacy: There are lapses in sustaining advocacy across changes in officers in government and political regimes. After the elections and establishment of a new government, the new Cabinet Secretary [minister of health equivalent] was not briefed sufficiently about the process of signing the compact; and declined to sign it.	
FCDO has been **working to convince the PS** for health that family planning is essential, to explain that family planning is a vital economic and development issue. As part of the FP2030 team, they (FCDO) went to meet with the PS for Medical Health Services in the MoH (KEMSA is under him), when funds were cut from the budget for commodities (and they were hearing about stock-outs across the country). (There is a remaining 500 million Kshs to be freed up still). There has to be a lot of lobbying in MoH to push for the funds to be allocated to the family planning products. There are politics, religious factors, and many actors – which are all challenges. FCDO participated in a **podcast** (through Nation Media) with Charity from UNFPA Country Office earlier this year, which was well received. It was the introductory podcast for a series on family planning. This is key **to reaching youth** (important, with the high teen pregnancy rates and other issues) to inform and encourage demand. Issues were raised around culture, the need to have these discussions in a safe space. Issues were mentioned around the "**triple threat" for women and girls** - teenage pregnancy, sexual and gender-based violence (SGBV), and HIV/Aids (with the high risk of HIV, FGM still be practiced in some places, need for FP). https://nation.africa/kenya/news/gender/inside-new-plan-to-tame-triple-threat-among-adolescents-4542438 FCDO has a "Development Impact Board" project for two years, to target adolescent girls and women of 15-20 years old, and reduce teen pregnancy. It did well, and "was picked up by the UN". It is co-financed by the private sector.	KII with FCDO. October 2024
UNFPA led the advocacy efforts and signing of the Compact. The Kenyan government took some time to sign but eventually warmed up to the idea of contributing to the financing of the family planning /RH commodities. The government has recognised the bargaining power that UNFPA holds in the sourcing of affordable FP. The **government of Kenya has made an allocation in its budget for RH/family planning, and signed the Compact** as well as an MoU which includes a roadmap by the MH to **gradually increase the national budget allocation for the procurement of commodities up to 100%** in 2026. However, there are challenges that still lie in the actual prioritization and disbursement of funds for the procurement of family planning commodities. This may pose a problem to meeting the stipulated targets. -UNFPA through the Supplies Partnership has implemented Smart Advocacy efforts. -The Compact is good for Government commitment, although disbursements are lagging	KII with KEMSA. October 2024
JHPIEGOo conducts **advocacy with UNFPA for domestic resource mobilization for family planning**. JHPIEGO uses its convening power to mobilize stakeholders (health and non-health) at the national level to facilitate release of the funds allocated for family planning interventions. They have a 1-year action plan for this and have the "tough conversations with Government".	KII with JHPIEGO. October 2024

Assumption 4.1 The Partnership, through UNFPA Country Offices and partners, effectively supports national authorities to significantly **increase and diversify programmatic financial contributions, as well as to prioritize reproductive health** as a core element of sustainable development by governments.	
family planning is not being prioritized enough in government; the current political environment is 'not enabling' for the prioritization of family planning. This is disruptive for FP programme implementation. Re-initiating the conversations to get government buy-in is usually very difficult.	
UNFPA has helped lead the Smart Advocacy initiative. UNFPA has the credibility and buy-in of the government, making it easier for them to influence the government to strengthen health systems. UNFPA has been using smart advocacy with Government to ensure supplies and funds are allocated and then get released by Treasury. **Country Compact is a good tool**. However, it was developed at the global level and to some extent **failed to appreciate the existing progress and efforts in Kenya**. Initially, Kenya had an MoU with the government and main family planning donors (FCDO, BMGF, USAID) on supply of family planning commodities. However, then the Country Compact was introduced, mainly as a discussion between UNFPA and the government, without enough synergy with the existing MoU. The donors/partners need to "get their voices together." UNFPA is too close to the Government, they don't want to push too hard re: reducing rights of girls, parental consent laws, etc. Around issues like comprehensive sexuality education in younger school years, no one wants to take this topic on strongly with Government, but UNFPA could push this. As a UN agency, they "play it safe" in countries (diplomacy), while speaking loudly globally. **<u>Resource mobilization:</u>** UNFPA could do more. They are "**very reactionary**". Only when the national Budget is passed in Parliament do people start talking about the things needing funding. But this is too late! UNFPA works closely with NCPD which is good. **Continuous advocacy is needed**. The **budget process takes a year, and UNFPA gets involved too late in the process**. They should work more closely with partners (e.g. Thinkwell, CHAI, NCPD) and start the advocacy earlier. This cycle, FP had 3 billion Kshs, which was reduced to 2B, and finally to only 500M. Partner coordination is a challenge, around advocacy. So, too much is left up to MoH. This is "low hanging fruit" for UNFPA to take the lead on. **Coordination has improved on the supply side but is needed more on the advocacy and funding lobbying side**.	KII with ICRH-K. October 2024
The ordering delays mentioned in EQ.2 negatively affect the government's budgetary allocation for FP because FP are not considered a strategic commodity; this then creates the perception of low budgetary absorption, and consequently reduced budgetary allocations in subsequent financial years. The SCMU needs to be sensitized on the Kenyan financial cycle. SP is working with other partners (e.g., FP2030) to push government to honour its commitment to increase financing for FP incrementally towards the target of 100% and actually release the funds. InSupply engage with SP in **conducting advocacy activities and facilitating an enabling environment for uptake of new products** through support for development and dissemination of policies and guidelines.	KII with In Supply. October 2024

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They are engaging with the SP to **lobby with policy makers and regulators** to **secure buy-in for innovative practices** such as private sector engagement to optimize availability of family planning products, and authorization of pharmacists to administer FP. Different members of the InSupply team sit on different TWGs and advocacy groups. They are very involved with UNFPA and the SP, at different levels. They do advocacy around policies re: enabling environment for NLUs, cascading policies (e.g. re: self injection) from national to sub-county teams. They also do advocacy around FP in private pharmacies, advocacy with the Pharmacy and Poisons Board and professional associations to enable this. They are also working with partners to include more family planning in the pre-service curriculum for HW training/education. Then this will be followed up with in-service training. UNFPA contributes to convening PMB, driving policies and guidelines, pushing for TMA, advocating for pre-service training (when UNFPA are at the table (e.g. in FP task force, TMA task force), it helps! UNFPA is "big brother" presence, instrumental. **Information, coordination** – "from competition to collaboration" among partners. They are now "all driving the same agenda", and Government starts to see it is essential to prioritize FP. They are working on messaging re: data on school enrolment versus. drop-outs, maternal deaths (highest in younger women). The environment doesn't allow them to be very vocal re: family planning in younger girls/women. But they work on the enabling environment and data. UNFPA and the SP drove the development of the new "Self-Care Guidelines", which is waiting for its national launch. There is good info there on self-injection and other topics. This has never been done before (especially around post-abortion care).	
There was lots of discussion among partners around the Compact and the MoU with development partners and Government of Kenya, about the commitments, etc. Now that Sam is in Kenya office, he will be engaged more in these discussions in country. BMGF funds and commodities go through CHAI for Kenya.	KII with BMGF. November 2024
USAID works with UNFPA in advocating for domestic financing for family planning. They are a member of the family planning Group, with regular meetings. They are advocating with Government to release the promised 1 billion Kenya shillings for family planning. USAID works with UNFPA to engage Government (MoH and NCPD), and both donors fund NCPD for its advocacy efforts. USAID funds FP2030 out of the Washington DC office, to support Dr Sheilah Macharia's work and UNFPA work around the FP2030 commitments. They all provided technical support in development of the family planning Advocacy Toolkit and costed implementation plan (five years, expiring soon?) USAID is involved in advocacy around tracking of commodities. They (with UNFPA and others) met with the PS for Health Services last month (Oct 2024), and he became a "champion" of the importance of family planning. They worked on the Investment Case	KII with USAID KII Nov6

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for addressing unmet needs in family planning, to convince Government and the PS for Treasury, and are now trying to meet with the PS for Economic Planning (NCPD is trying to set it up). They are advocating for post-partum family planning, working with technical experts to drive this in Kenya	
The **Human Rights Commission partners with UNFPA to develop tools on media advocacy and reporting – how to report and disseminate information on HR issues**. The Persons with Disabilities Act has not yet passed but is coming. They are developing a tool to report on human rights, and a tool for SRH reporting (with which all implementing partners can then report). They are also working on a bill on inter-sex persons. Because they **focus on Government accountability**, they can check at service delivery level, to ensure Government is honouring its commitments under the Country Compact. Their chairperson sits on the Medical & Dental Council, a forum where they can influence reforms needed in the health sector. The HR Commission has been working on county initiatives, piloted in 12 counties. They **pilot the UHC** concept in Level 5 hospitals (in collaboration with UNFPA) around existing challenges for marginalized groups and developing tailored improvement plans (following a self-assessment report) for follow-up. The focus is on **SRH rights in the health sector**; needing to have health workers recognize these rights (e.g. for lesbian, gay, bisexual and transgender persons). They have had interaction with UNFPA around **sensitization of health workers**, through joint forums, gatherings, discussions about human rights, commitments, et. They provide capacity building of health workers in human rights, documenting human rights violations (doctors are good at pointing out these violations). With these cases, they sometimes have to take the Government to court (sue the state). They have an MoU with Kenya Medical Women, and collaborate with MSF, Red Cross and others – this way, they are able to link the HR Commission with the victims (e.g. victims of violence during police crackdowns). Assessments at county level look at the health facilities, CHP access challenges, and focus on the **human rights-based approach**, and principles of **LNOB**. The counties categorize those who are marginalized (according to Ministry of Social Protection records), and they see what the county can do to improve access for these people.	KII with Kenya Human Rights Commission. November 2024
Through the SP UNFPA started the **4-episode podcast** in April 2024. Nation Media worked with UNFPA on the concept and topics to address; and UNFPA invited the guests. (UNFPA now owns the content, with Film Aid Kenya, to circulate, replay, share as they wish). The podcast series was hosted as follows: ●Ep#1: Expanding choices in family planning. Guests: Akaco Ekirapa, the British High Commission, Head of Health Programmes and Charity Koronya, UNFPA Family Planning Specialist. ●EP#2: Public/Private Mix (guests were Marie Stopes Kenya, and Nairobi County officials). Busting Myths and Misconceptions around Family Planning. Guests: Community health promoters. Working with Nation media, there was a mobilization effort of community health promoters. Nation media was also involved in documenting the footage from the field	KII with Nation Media. October 2024

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●Ep#3: The Power of Family Planning - Where do you seek advice on contraceptive use?. Guests were Community health promoters working in poor areas. (Audience was mostly CHWs in Kenya) ●Ep#4: Is Kenya committed to its family planning programme? Guests: Dr Sheila Macharia, Managing Director East and Southern Africa FP2030 and Dr Edward Serem, Head of the Maternal and Reproductive Health Division at the MoH. This was the most watched episode. Over 24K views, with viewers from US, UK, Nigeria, Norway, Canada, Germany, and South Africa. UNFPA hosted a consultative process and workshops with various stakeholders which led to the development of the Advocacy and Communication tool on SRH, as well as a Media engagement tool.	
Coordination of partners for advocacy efforts around FP2030 has improved. Everyone is now "more together, united, and motivated" with the "looming crisis" posed by the upcoming end of FCDO NESIP funding. There are "different touch points" for advocacy with the Government, but all partners have been involved in advocacy, lobbying the PS, etc. **Options, FCDO and UNFPA did advocacy and developed a Costed Implementation Plan, with Government expected to take over the family planning programme and funding in 2026**. This process was "going ok" until two years ago with the new Government, and since then it has gotten worse. Austerity measures are now in place, after the June-July Nairobi protests. Family planning funding was cut in half (by 500M Kshs). There is hope this funding will be restored. Advocacy efforts such as the **smart advocacy that PSK has been actively engaged in -** is a way to try and restore some of the gains made earlier when the government committed 1 billion Kenya Shillings to family planning commodities. Austerity measures introduced by the new political regime in line with recent finance bill have contributed to the budget cuts on family planning commodities; this creates the risk of reversal of gains made in the Government's commitment to increase funding for family planning commodities. DESIP is coming to an end next year which creates a potential crisis for funding and availability of FP commodities in the country because FP is not considered a priority commodity for the country. UNFPA funded the political economy analysis (PEA) of why the government's commitments to fund as per the compact do not materialize through release of funds. The evidence from this PEA will constitute evidence to be used to inform further smart advocacy strategies PSK is part of the group of partners who have come together to advocate for family planning commodities at subnational level among and through the caucus of women governors. There is lack of a person who is passionate about the family planning agenda at both the national and sub-National level within Government. There are some (e.g. PS in health department) who have become convinced of the critical nature of family planning as part of development, but others who block efforts to increase access PSK also carries out social mobilization to generate demand and uptake for family planning.	KII with PSI-Kenya. October 2024
RHNK brings a **voice from the private sector to advocacy and forums** (where UNFPA is a leader). RHNK was a big beneficiary of the workshops led by UNFPA - e.g. Ratis (?), monitoring of stocks, TMA task force (they are a member), smart advocacy, NOMT	KII with RHNK. November 2024

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(they are part of the NOMT based at KEMSA for demand), needs & review of policies e.g. family planning policy. They are also part of the national forecasting and supply chain task force. Youth demand for the SRH/ family planning services and products has risen. **UNFPA is a big supporter of their youth ASR conference. UNFPA supports RHNK with training, advocacy, youth-friendly services, and increasing capacity of providers to offer youth-friendly services**. (Their youth network is critical - these are champions for youth in the communities). Kenya has policies and a Constitution, but there are **discrepancies between the Constitution and the laws** being applied, which creates **problems for the enabling environment**. There is a conservative, hard-right faction ("opposition") that interferes with policymaking and laws. The age of consent used to be a big problem. The opposition uses this to reduce access to services, saying that young people don't have sex. But "the numbers don't lie" and youth face a "triple threat" of HIV, teen pregnancy, and GBV. There were norms drawn up, but the opposition pushed them back. **UNFPA brought all partners together to address this problem**, and it is an ongoing conversation using their local and global reputation. They **now have a multisector coalition, with champions to speak u**p against this opposition, have honest discussions with policymakers. Using evidence to make the case for the importance of access to SRH/ family planning care and other services for youth.	
Signing of the multi-year Compact showed some commitment by Government of Kenya. But the Government does not necessarily prioritize family planning. When the country is discussing the supplementary budget, one of the budget lines that is affected and not prioritised is that of family planning. Also, within the country, it is difficult for people to link family planning to socio-economic development. The **National FP Policy** is still not finalized, and the RH policy is in court (due to resistance to SRH in young people, push-back from religious groups and the far-right opposition). There have been **many advocacy activities** undertaken through the SP. UNFPA hosted the Smart advocacy initiative which led to one of the Permanent Secretaries declaring themselves as an family planning Champion. UNFPA has worked with NCPD on several of its advocacy activities which have made the difference. This has translated into actual commitment: The family planning champion within the government; Government signing the compact. (But funds disbursements have not followed as were committed). **Domestic support for family planning has a growing funding gap, which is now approx. USD 14.9M**. There is a challenge of commitment versus disbursement of funds. The Compact was signed in 2023 (which was not an easy process), but the Government said "why should we give money to the UN?!"	UNFPA Rep and key staff meeting. October 2024

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Annex A was annual but is now multi-year. Signed most recently for 2024-2026, with agreement by the Government to increase their contribution by 10% each year. The domestic allocation for FP commodities was 863M Kshs for 2019/2020, and 1.19B Kshs for 2023/2024. However, the actual amount disbursed went down from 870M to 430M due to wider budget cuts. Government funding and budget cuts are a constant challenge. The Government had signed an MoU with FCDO, BMGF, and USAID (in 2019), but hasn't honoured the MoU. The Government says it was signed under the previous Government and not by MoF/Treasury, so it is not valid, and the donors "should go back to the drawing board." (The regional DMPA-SC conference was held in Kenya in 2021, and this made a big impact in awareness) Universal Health Coverage is an ambition, a work in progress in Kenya.	
Two doctors (at MoH and ICRH) (member of Steering Committee for SP) were instrumental in getting the Compact signed. There was **work to sensitize the Government** to the critical nature of family planning as part of development. One of them informed MoH about the impact in case Government were to withdraw its support. It was clear that Government does not want to lose UNFPA support for commodities. The process was so long, involved the AG, partners, development partners. A **big issue in Kenya was that they had signed an MoU in 2019 with the FP partners** (USAID, BMGF, FCDO), and now here came the Compact in parallel. Government was "confused and suspicious" about UNFPA bringing in something new, asking Government to give money. UNFPA had to bring USAID and FCDO on board with the Compact, but they too asked why, when there was an MoU already in place. There were challenges for UNFPA around Government engagement and getting them to agree. For the Compact to be well received, the UNFPA Kenya Country Office had to link it to the country programme. For the compact, UNFPA seemed to have engaged with the government on their own instead of bringing other partners The approach under the compact is supposed to be standard and across the board for all the 54 countries that are part of the Supplies Partnership. However, the realities on the ground are much different. Respondent was not happy with the classification of Kenya as a carry-over country - it does not reflect the ongoing reality. It seems like a problem of averages that made Kenya look like it is doing well. (e.g. very low CPR (2%!) in some places and high (85%!) in others, plus financial challenges, country context (averages for country look adequate, but hide problems in the worst areas). The indicators are not appropriate for making the country a "carryover" country, with an expected 10% contribution going up each year.	KII with UNFPA SRH/FP specialist. November 2024
[...] contributions to be made by the Government in respect of USD 172,600.000 which shall be 10% of USD 1,726,000.000 in 2023/2024 and USD 345,200.000 which shall be 20% of USD 1,726,000.000 in 2024/2025. The first contribution by the Government shall be for FY 2023/2024. First addendum shall be deemed to have come into effect on August 28 2023.	Kenya MoH (2023). Signed Compact of Agreement between the Government of the

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	Republic of Kenya and the UNFPA for the UNFPA Supplies Partnership. (pg1)
Annex A stipulates budget for routine and NLU commodities of USD 2M by UNFPA, and USD 345,200 by Government for 2024. UNFPA annual budgeted amount remains the same through 2027, with Government's portion rising to USD 618,473 in 2025; USD 824,631 in 2026; and over USD 1M in 2027.	Kenya Country Compact signed May & June 2024 between Government and UNFPA, for period through May 2024 through Dec 2027 (pg11)
Although the government committed 1.19 billion shillings for the 2022/23 financial year, no funds were disbursed for commodity procurement during the same period. This means that unless action is taken, Kenya faces grave socio-economic impact on its population.	Kenya National Council for Population and Development (2023). Family planning: the core of achieving Kenya's transformative agenda. (pg2)
Conclusions: This policy brief identifies two major gaps, thus: i) The National Treasury does not allocate adequate funds to support a stable, sustainable and predictable access to FP commodities; and, ii) There is often late and unpredictable release of family planning commodities funds to the procurement agency to allow for efficient and effective procurement timelines. Recommendations: The policy brief recommends that: i) The National Treasury allocates adequate funds for family planning commodities as projected in annual forecasting and quantification reports; ii) Promptly release to KEMSA all funds allocated for family planning commodities; and, iii) Strengthen coordination with the development partners to support other aspects of family planning system strengthening.	Kenya National Council for Population and Development (2023). Family planning: the core of achieving Kenya's transformative agenda. (pg13)
The level of unmet need for family planning is still considered to be high with wide county disparities in mCPR and unmet need for family planning.There is more scope to increase the availability and use of family planning service through increased investment,	Kenya National Council for Population and

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including additional financing through public and private health insurance. Despite the increasing government funding of family planning commodities, there is still a huge gap in funding to ensure continued reduced unmet need for family planning. This gap can be reduced significantly by leveraging both public and private health insurance. Health insurance remains an untapped financing scheme for health services, particularly family planning services.	Development (2023). Inclusion of family planning in public health insurance: the potential gains. (pg6)
Kenya was reclassified as a lower middle-income country in 2014 which has meant it is not a priority for development assistance leading to a reduction in funding these strategic programmes. The leadership of the MoH and the NCPD acknowledges the looming family planning commodity stock-out and related consequences. They are also acknowledging that much more needs to happen to ensure strengthened health systems for maternal and child health including family planning. A memorandum of understanding between development partners supporting FP commodity financing and the Government was signed on 16 November 2021 signalling a transition from donor support to domestic financing of family planning commodities by the FY2025/26. As the donor support gradually decreases, the Government is expected to step up its financing to fully cover the costs and the demand for FP commodities to the last mile in the country.	Kenya National Council for Population and Development (2023). MoH, Development Partners and FP Stakeholders Breakfast Meeting on Reproductive Health Commodity Security Report, 23 November 2023. (pg2)
Progress in domestic financing for health (summary): We are not investing enough in health to realize our UHC goals & commitments because: a. Minimum General Government Expenditure (GGE) on health target should be 15% (Abuja declaration) b. Minimum of the County budget allocation for health should be 35% ii. We are not using the available resources efficiently. Using the current resources efficiently can improve health outputs & outcomes by up to 30% iii. At the county level, there is evidence of low adherence & capacity to adopt the PBB approach to planning & budgeting iv. More funding in Kenya is going towards curative care (27%) as opposed to preventive care (8%)	Kenya National Council for Population and Development (2023). MTEF FP Programme FY 2024/2025 Concept Development Workshop Report on 5th to 7th July 2023. (pg7)

Assumption 4.2 The **advocacy and data generation** efforts of the Partnership contribute to influencing and generating pressure on power holders, which translates into **political commitments, including national development plans and strategies** aimed at strengthening health systems. [links to theory of change causal assumption 10].
Indicators **4.2.1** Advocacy strategies (private and public) and workplans included in programme planning documents and advocacy tools. **4.2.2** Country reports contain substantial references to national-level government advocacy. **4.2.3** Global monitoring data on advocacy initiatives, showing coherence between global and national strategies in reproductive health/family planning and UNFPA Supplies advocacy and communication messages.

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4.2.4 National reproductive health/family planning strategies and plans (including in national health plans and reproductive health roadmaps) focus on expanded access, including access for marginalized women and girls, and whenever possible, evidence of influence of UNFPA (e.g. reference to data, studies, publications, etc). **4.2.5** Percent of Partnership countries where reproductive health commodities have been included for the first time, or increasingly prioritized, in PHC and UHC plans with a focus on expanded access and active measures to reach marginalized population groups. **4.2.6** Stakeholders' views on how advocacy has contributed to strengthening health systems, including improved access for marginalized population groups. **4.2.7** National, regional and global level UNFPA-generated or UNFPA-consolidated, regularly updated, and well-disaggregated datasets for Reproductive health commodities. **4.2.8** Documented and/or reported Partnership use of UNFPA-generated or UNFPA-consolidated, regularly updated, and well-disaggregated datasets for reproductive health commodities for advocacy purposes.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
UNFPA supported NCPD and other partners in the **training of CSOs and other partners in Smart Advocacy**. There are three actions/strategies they are using in Smart Advocacy at present: 1) trying to get back the money they lost for family planning in the budget (the 500m K sh's), 2) getting family planning included in the budget as a firm line item, and 3) getting family planning officially included under private health insurance. CSOs have high staff turnover, so they always have to train and retrain. They (NCPD) only work at national level, but the counties are key for advocacy too (they need to scale up, get down more to county level in their advocacy work – working through County Assemblies). NCPD is a "lean and mean" agency, but they do have 11 regional offices which support all the 47 counties. The **Partnership supported development of the fsmily planning Advocacy Kit**. NCPD worked on advocating for family planning as an essential economic and health development issue and used the UNFPA-supplied language. (The PS became a champion, now a believer in the essential nature of family planning).	KII with NCPD. October 2024
Options is working with other partners including UNFPA to **advocate for increased domestic resource mobilization** towards family planning commodities. Prior to the Compact, there was a pre-existing agreement between government and partners on counterpart funding for family planning commodities on an incremental scale. This approach was satisfactory to stakeholders. In recent years, allocation of funds has not translated into release of funds, therefore there are inadequate funds for FP commodities. Options is **collaborating with UNFPA to carry out a political economy analysis (PEA**) to gather insights into the barriers & facilitators of availability of money for family planning commodities. PEA findings were shared at a stakeholder forum; report is almost done. Next step is a high-level meeting to deliberate the PEA findings for presentation to the decision-makers. The Compact is a positive move to mobilize countries to contribute towards family planning commodities; is a catalyst for the increasing domestic funding for family planning commodities	KII with Options. October 2024

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Family planning is not perceived as a priority because the risks are not immediately perceptible; not mapped to other maternal health challenges. MoH gets a 'basket-fund' from the Treasury; allocation to various programmes happens within MoH; FP is given low priority compared to other competing priorities, and vulnerable to budget cuts. There is a need for internal champions within MoH to ensure funds committed to family planning are honoured. Options have participated in the **Smart advocacy forums funded by UNFPA**; other participants include the Treasury, MoH, NCPD. NCPD collaborating with them and other partners **to build a business case to advocate to the government of the benefits of investing in family planning** as an economic development agenda item. FP2030 also holds the Government accountable for keeping the ICPD commitments. NCPD needs to synergize with MoH to amplify the advocacy for financial allocation and release; however, MoH is not proactive in advocating for FP; and lacking a sense of urgency for the family planning agenda. The shift under the SP to a **Compact mechanism** was a positive move. Ensures that countries supported are part of the process. They've signed/committed, now how to do more. Advocacy to Government is ongoing to fund family planning (release funds) as committed. The process was as always ("you always have to drag the Government"). NCPD is very active, but they're under The National Treasury and Planning (So NCPD is a state corporation within this ministry). NCPD needs MoH to convince Treasury to fund. But MoH has not been proactive in advocating for this. With the devolved nature of service delivery, the MoH headquarter is "not feeling the pinch" or urgency to move on this. Once funds are allocated by Treasury, it comes to MoH as a lump sum (not by line item), and MoH depts have to fight for their funds which are then allocated by MoH.	
Through UNFPA support, implementing partner NAYA has been able to **develop the capacity of AYP champions for ASRH**; these ASRH champions conduct **advocacy activities at community level.** NAYA has been carrying out ASRH advocacy activities with county governments to increase allocation of domestic resources for ASRH. NAYA works with the Youth Advisory Councils for Health at county level; and has youth advocates helping reach youth in communities. Youth ARE being served, no matter the restrictions/constraints.	KII with NAYA. October 2024
As an Implementing Partner of UNFPA, NAYA has participated in **stakeholder engagements** supported by the SP for the development of a business case to advocate to the national government to invest in FP commodities.	KII with NAYA. October 2024
UNFPA supports MSI and other members of the SRH caucus to hold **meetings with lawmakers to advocate for buy-in of ASRH services**. The SRH caucus do joint advocacy work and have held meetings with the health committee and budgetary committee to advocate for the government to honour commitments as per the compact and other agreements. They also **work with Parliament on contentious bills** (e.g. age of consent) and engage lawmakers to create allies within the health committee who will then be champions (and able to speak with authority) on these issues. **SP has supported MSI to conduct advocacy activities** with the	KII with MSI-K. November 2024

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county health management teams to adopt post-abortion care interventions in their annual workplans to enhance service availability. MSI works with UNFPA in all the eight priority counties, through methods, training of health workers and CHPs, information sharing, etc. SP supports MSI to document success stories which they use to conduct advocacy activities to support community members to make informed decisions on family planning. UNFPA communications team supports them to package their messages. They also link them with media organizations and provide them with training on how to maintain confidentiality when disseminating the stories.	
Key accomplishments in 2022 through UNFPA Supplies Partnership support: Development of a business case for the inclusion of family planning services in public and private health insurance schemes. To ensure sustainable domestic financing for family planning, UNFPA provided technical and financial support to NCPD to develop a **business case for the inclusion of family planning services in public and private insurance schemes**. The business case provides information on the cost of activities that will be undertaken, and the health benefits obtained from the inclusion of family planning services in the insurance schemes. Additionally, the business case will bring visibility to the need for inclusion of family planning in insurance to the insurance entities, policymakers, and other stakeholders, and will serve as a key advocacy tool to help in reducing the family planning commodities funding gap. It is envisaged that the funding gap can be reduced significantly by leveraging on both public and private health insurance which remains untapped. The framework that seeks to include family planning P in health insurance underwriting also aims to prepare the industry on equity for family planning service provision alongside the Total Market Approach Strategy.	UNFPA (2023). Kenya Country Narrative Report 2022. (pg3)

Assumption 4.3 The **financing structure and co-financing schemes** of the Partnership contribute towards incentivizing countries and securing political commitments (both financing and relevant PHC and UHC strategies and plans).	
Indicators **4.3.1** Documents that evidence the utility of the existing financing structures and co-financing incentives applied to the different levels if support provided (full, modified, technical and transition). **4.3.2** Perceptions of stakeholders about the adequacy of the financing and co-financing components (HSS, Match Fund, etc.) to increase political commitments and move countries along the pathway to sustainable transition. **4.3.3** Increase (number and frequency) of political commitments in Partnership countries. **4.3.4** Percent of Partnership countries who agree funding streams are efficient and relevant to their contexts. **4.3.5** Documented explanations of the rationale for application of different funding streams, and regular review. **4.3.6** Percent/ratio of different funding streams applied across Partnership countries	
OBSERVATIONS	**SOURCES OF EVIDENCE**
NCPD are exploring with UNFPA **working with private health insurance** to include family planning (private health insurance is not really talking about or supporting family planning now). They want to get comprehensive family planning officially included in	KII with NCPD. October 2024

Assumption 4.3 The **financing structure and co-financing schemes** of the Partnership contribute towards incentivizing countries and securing political commitments (both financing and relevant PHC and UHC strategies and plans).	
private health insurance. They met with the insurance regulatory authority recently to push this issue. They are also trying to build more family planning champions in Kenya	
Counterpart funding (CPF) works for HIV, vaccines and other programmes. UNFPA should consider counterpart funding to Kenya. (Wikipedia: "A counterpart fund is a fund established as part of an arrangement for converting foreign aid (often supplied in $US) into an account in the domestic currency").	KII with MoH SRH technical team. October 2024
There was a dedicated family planning budget line, but with the new Government, constrained budgets, and austerity measures, family planning funds have been decreased.	KII with MoH SRH technical team. October 2024
Government made commitments under the Compact, but with budget cuts, the disbursements haven't matched these to date. The Compact was a difficult process, took too long to get signed (by the Cabinet Secretary (CS) for Health, who is new). The key stakeholders in health do not review the Compact regularly, but they should. MoH/Government wants more development partner coordination on this. How is it enforced? UNFPA cannot do much, and they say "we are not political" (as a UN body), so they "step back" from enforcing the Compact commitments. FCDO has the "hard conversations" with Government. It was the UK that drove the MoU, pushed USAID to participate and do their part, and also to reduce their contributions over time as FCDO is doing.	KII with FCDO. October 2024
The Government of Kenya has implemented programmes to enhance the achievement of UHC which consist of free maternity and abolition of user fees in primary health facilities. Other initiatives are health insurance subsidy programmes for the elderly, the very poor and persons with severe disabilities, EDU Afya for all students, the launch of UHC pilot programmes in four counties and scaling UHC to other counties. The free maternity service financing covers family planning services in public health facilities. The National Health Insurance Fund (NHIF) and some private health insurance firms also cover family planning in their health packages. However, in practice, they rarely make this provision explicit to clients, so family planning is rarely covered.	Kenya National Council for Population and Development (2023). Inclusion of family planning in public health insurance: the potential gains. (pg2)

Assumption 4.4 The Partnership's mechanisms and tools to ensure **sustainability** contribute towards (and adequately measure) incentivizing countries and securing political commitments (both financing and relevant PHC and UHC strategies and plans).
Indicators **4.4.1** Documented evidence on the adequacy of the Sustainability Readiness Tool – systems readiness assessment tool to effectively identify gaps and bottlenecks in the different programmatic areas and inform decisions around the types of activity supported through the HSS funding stream. **4.4.2** Percent of Partnership countries using SRAT and results / subsequent improvements in domestic financing. **4.4.3** Percent of Partnership countries that have signed Compacts and increased domestic financing **4.4.4** Perceptions of stakeholders on the relevance of the Compact and Annex A, including frequency of renewal.

Assumption 4.4 The Partnership's mechanisms and tools to ensure **sustainability** contribute towards (and adequately measure) incentivizing countries and securing political commitments (both financing and relevant PHC and UHC strategies and plans).	
OBSERVATIONS	**SOURCES OF EVIDENCE**
The Compact was a tough, long process (8-9 months). It was a **unilateral document by the United Nations**, and **the country was not part of it**. It was **not a consultative process**. There was a lot of **pressure on Kenya to sign or be removed from the SP list of countries**. After the Compact was signed, they were not able to move the funds from Treasury, as Treasury pushed back and refused. The United Nations should involve the country in the process, not impose this on the country. The national decision maker is the MoF (National Treasury), on everything to do with funding. The Government is committed to the FP2030 agreements, with top level commitment. The Government had a family planning policy as part of their development programmes, with a budget line. It was doing well up to 2022. But the new Government (which came in 2023) sees family planning as non-essential. The country has a heavy debt burden, which is hard to cover, so it's a very difficult fiscal space now. The **Compact has hurt the relationship**, although **Supplies Partnership has been a "backbone" for them**, and they want it to continue. There are not clear deadlines for them in the Compact. What is the end game for UNFPA in forcing the Government contribution? Are they (UNFPA) building a business, taking over the procurement to build their own business? They have KEMSA, have invested heavily in it, and the systems are strong in country. But UNICEF and UNFPA insist on buying their own products, which undermines government systems. MoUs/agreements need to be friendlier to the country. The process must be consultative. They signed the Compact under pressure. The MoU they signed with key family planning partners (BMGF, FCDO, USAID) in 2019 (through 2026) entailed funds being given off budget (not to the Treasury), so the money is not there on the ground. USD 30M is their family planning need/requirement (per year?).	KII with MoH SRH technical team. October 2024
The Compact was a "brilliant idea", reinforcing the FP2030 commitments, and stipulating the Government should reimburse UNFPA 10%, then 20%, then 30% per year for family planning commodities. (The FP2030 commitments are for Government to fund 100% of family planning commodities by 2026 (but now Government is at less than 50%). Under the finance bill of 2024, family planning **"was the first casualty"**, from 1B KSh, it got cut down by 50%. (There is a Track 20 meeting to track Government commitments, but "no one wants to push the Government on this"). Forex is another challenge, with the weakened K. shilling. After the annual family planning quantification exercise, there is a Supply Plan developed for the year. But coordination of MoH, Country Office, UNFPA, SCMU should be better. By the time UNFPA gets the info, it's too late. UNFPA is on a calendar year, whereas the Kenyan Government year is July-June - misalignment! SCMU needs to better understand the country cycles and financial year (Government needs to spend before June!). Despite the signing of the Compact, FP is still "not yet on the agenda" of Government.	KII with In Supply. October 2024
The Country Compact (now 2024-2026) was not an easy process! (The first one was only for one year). The MoH, AG, MoF Cabinet Secretary (equivalent to Minister of Finance), UNFPA all had to sign. NCPD sat with them for three days to coordinate the process. Government listens to them (NCPD) and then allocates according to commitments. The Compact enforces that Government must co-pay, and that money goes to UNFPA. The Kenya Government commitments under the Compact are 10% for the first year, 20%	KII with NCPD interview . October 2024

Assumption 4.4 The Partnership's mechanisms and tools to ensure **sustainability** contribute towards (and adequately measure) incentivizing countries and securing political commitments (both financing and relevant PHC and UHC strategies and plans).	
for second year, 30% for third year. They (NCPD) don't sell family planning as a health issue, but as a development issue. The fact that Government signed is key. Now they are fighting to fill the gap between what was committed/allocated, vs. actual disbursement from Government. When the new Government came in, they were "back to square one." The change in political regime after the 2022 elections was a risk for the milestones gains due to changes in priorities which resulted in budget cuts for family planning commodities. Through advocacy, commitment was achieved with the MoH PS of Medical Services, who was convinced to allocate 1 billion KES for the Compact commitment. UNFPA has been funding Kenya through the national Treasury. (Treasury/MoF doesn't trust or co-finance, when donors give money off budget). The Compact is a good thing, to hold the Government to account, even if there are delays in disbursement – the commitment is still there. (And Government is now dealing with a lot of difficult issues and fiscal constraints, and there is an austerity budget in place with many cuts).	
UNFPA funding is quite small, and requirement that Government contribute 10% is a "drop in the bucket" – but still challenging for Government, in these times of austerity and budget cuts. The **Match Fund is good in theory**, but this is a constrained fiscal space. Government is paying 80% of their funds to pay down their debt (invested in Euro bonds?). (**Government isn't making their required contributions, so not eligible for Match Fund yet**).	KII with CHAI. October 2024
The **Compact is too much of a cookie cutter approach**, treating all 54 countries the same, when their capacity and context are so different. The Compact came in while there was still an MoU for family planning with key partners (FCDO, USAID, BMGF). The Compact should have more aligned with the MoU, and UNFPA is acting like Kenya is starting from zero, whereas it should have been building from what was already under way in SRH/FP in country, and work to build on national systems (not create parallel ones). The Compact should have offered incentives to bring in new products. Governments (including Kenya) are procuring essential medicines, so they do have capacity. By taking procurement out of Kenya (handled by UNFPA SCMU), they are not strengthening national systems. They must work within the system, if want to build sustainability	KII with FP2030. October 2024
The Supplies Partnership Compact was signed in 2023, and then again in 2024, with the new Government. USAID were not part of the process, but were part of the effort to build visibility and commitments. The Compact ensured Government commitment. But when there were budget cuts at Treasury, family planning was "the first to be cut". The Mid-Term Expenditure Framework (MTEF) process is ongoing now, where MoH departments have to lobby for funds for their programmes (e.g. RMCAH and Nutrition). USAID is working with Ministry of Finance on this. The NCPD has never lost their funding allocation – USAID wonders how. Probably because NCPD is there, fighting for their allocation (whereas SRH depts have not. There is a capacity gap there at MoH. Do they have a champion?) The PS is now a champion, which is important, as he is very high level. Family planning was allocated 1 billion Kenya Shillings (there are line items!), but the challenge is the release of funds.	KII with USAID. November 2024
The Compact has really done its job, really forced the Government's hand to commit funding. However, the Government is not complying with its own commitments. After a smart advocacy workshop, the MoH wrote to Treasury to commit funds to the Compact, making it clear that FP is part of the socio-economic development. They developed a Media Advocacy toolkit, to ensure the media understands their power to influence Government in this area. Disadvantages of the Compact were: it was difficult to	UNFPA rep and key staff meeting. October 2024

Assumption 4.4 The Partnership's mechanisms and tools to ensure **sustainability** contribute towards (and adequately measure) incentivizing countries and securing political commitments (both financing and relevant PHC and UHC strategies and plans).	
make Government understand it, it took a long time to get Government to sign, there was a lack of trust by Government (they didn't trust enough to sign, for a time), and the changing political landscape and new leadership coming in made it hard to maintain and enforce.	

EVALUATION QUESTION 5: To what extent are the **governance mechanisms, processes, and structures** of the Partnership efficient at supporting the achievement of other strategic objectives and to what extent is this supported institutionally by UNFPA?					
CRITERIA	EFFICIENCY	**AREA OF INTEREST**	Strategic objective 4 – Governance and management	**LINKAGES TO THE THEORY OF CHANGE**	Linked to the orange box of the theory of change representing the "governance and management" dimension. Linked also to the underlying list of inputs included at the bottom of the theory of change.
RATIONALE	**This question addresses strategic objective 4 on operational efficiency and improved management with shared accountability for results.** This strategic objective is at the basis of the theory of change as it represents the basic conditions for the Partnership to achieve its expected goals. As a result, the capacity of the Partnership to deliver results is highly dependent on the achievement of this operationally related objective. As depicted in the reconstructed theory of change, this question focuses on three main modes of engagement: partnerships, integration and coordination, and governance. The areas of analysis considered for this evaluation question focus on the adequacy of the new governance and management structure (governance), as well as the strategy and implementation of external partnerships for synergetic results (partnerships). Moreover, the question addresses the extent to which the existing financial and human resources are adequate for the effective implementation of the Partnership, and the extent to which the four strategic objectives work in coordination as a system to maximize results (integration and coordination). The question also addresses efficiency toward achieving first-level results.				

Assumption 5.1 The improved **Partnership governance and management have increased the engagement** among main partners and promoted shared accountability for results and efficient decision-making. (Links to theory of change causal assumption 3.)
Indicators

Assumption 5.1 The improved **Partnership governance and management have increased the engagement** among main partners and promoted shared accountability for results and efficient decision-making. (Links to theory of change causal assumption 3.)	
5.1.1 Views of stakeholders on the Partnership governance and whether it has improved or worsened. **5.1.2** Views of country representatives on the Partnership efficiency in Phase III. **5.1.3** Documented improvements in governance processes within Phase III. **5.1.4** Experience and views of Partnership secretariat staff and Steering Committee members on the efficiency of new Partnership governance structures, systems and processes. **5.1.5** Documented examples of risk analysis and system analysis applied to identify gaps, challenges and weaknesses in Partnership governance and management **5.1.6** Decisions of the UNFPA Supplies Steering Committee reflecting inputs from donor partners, Partnership managers and other key stakeholders (e.g. civil society organizations (CSOs), UNFPA staff and national health authorities). **5.1.7** Stakeholders' views on the added value of Steering committee and sub-committees. **5.1.8** Partnership countries who agree that overall governance structures and processes of Phase III tadd to the efficiency at the country level. **5.1.9**. Records of the Steering Committee and sub-committee meetings indicate efficient decision-making processes and the added value of each governance body.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
The **Governance systems in Kenya** (NOMT, COMT, S-COMT) need to be strengthened. There should be mentorship sessions, and awards for best-performing counties, to motivate better performance.	KII with UNFPA SRH/FP specialist. November 2024
Yes, there is one Kenyan (from ICRH-K) on the **SP Steering Committee**, and "she tries". But she is from an NGO, why not have a representative from Government? It's not really enough country representation. Re: representation of the SP countries, what competencies do the people sitting on the Steering Committee have? Is there any space for Government to have a seat?	KII with MoH SRH technical team. October 2024
The SP has supported the formation of the **national order management team (NOMT**), county order management team (COMT), and subcounty order management team (SCOMT). inSupply are members of the NOMT. These committees oversee rationalization of family planning across the country, and between and within counties.	KII with In Supply. October 2014
Kenya has had strong representation in the governance mechanisms of the Partnership, with ICRH-Kenya serving on the global steering committee representing the CSO sector, and country level partners. More partners should be brought on board and there should be better coordination among the partners.	KII with ICRH-K. October 2024
There is a new Governance team (including BMGF and UNFPA) called the BMGF & UNFPA Leadership Group), which he is part of, to focus on the new USD 100M grant for focus countries (Nigeria, etc – NOT Kenya). There is also an Investment Portfolio Manager and a Country Technical Group to work on this new grant. In Kenya, bringing in the country voice (to the Steering Committee and other SP governance bodies) is very critical. Maybe SP should consider who is being included from countries and consider bringing in country finance leaders (MoF). Interrogate these MoF voices, get them involved. The SC has been dominated by international organizations. It was good to have ICHR-K (local	KII with BMGF KII. November 2024

Assumption 5.1 The improved **Partnership governance and management have increased the engagement** among main partners and promoted shared accountability for results and efficient decision-making. (Links to theory of change causal assumption 3.)	
NGO) representing Kenya on the Steering Committee, but it would be interesting to consider more Government engagement, and to think about which countries could have strong, respected, representative voices. If there is a country on the SC with a strong voice, championing family planning and with authority that others listen to, that would help.	
Governance in Kenya is at national, county, sub-county and facility levels. Kenya has been represented in the SP Steering Committee by ICRH, but this will now rotate (next country is Zambia) - the SC country representative is usually an NGO.	UNFPA Rep and key staff meeting. October 2024

Assumption 5.2 The selection of external partners for participating in the Partnership is based on complementarities and potential synergies between organizations, which have been efficiently sustained over time to maximise results. (relates to theory of change causal assumptions 1 and 5.)	
Indicators **5.2.1** Perceptions of stakeholders about the extent to which partners have been selected based upon complementarities and for maximizing / leveraging synergies, across different contexts (i.e. humanitarian contexts, development contexts etc). **5.2.2** Views of UNFPA country representatives on whether the relevant partners have been included within the Partnership in view of the objectives to be met at country level. **5.2.3** Documented explanations of the rationale for choice of partners.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
Stakeholder mapping was done by UNFPA for the new Country Programme (#10), (aiming for 0 unmet need, 0 maternal deaths, 0 GBV) at the beginning of 2024 to enhance coordination of activities, minimize duplication and address any gaps among partners, including for the Partnership. They found there was a gap on permanent methods, so MSI-Kenya was added as an Implementing Partner. The stakeholder mapping is dynamic and reviewed regularly.	KII with UNFPA SRH/FP specialist. November 2024
MSI-K were brought in by UNFPA as service providers to promote access to NLU, particularly permanent methods. They trained 48 healthcare workers (doctors, nurses, reproductive health clinical officers): 24 to provide BTL, 24 in performing vasectomy. They trained HCWs (doctors, nurses, clinical officers) based in Nairobi, Bungoma and Narok. They also ensure quality of care through follow-up visits to ensure practitioners adhere to standards of practice. They reported that the trained HCWs sometimes experience challenges with availability of medical supplies and equipment to provide the services. They are collaborating with MoH through ToT trainings to integrate the services in public sector facilities for sustainability. MSI also works in the 5 UNFPA priority counties to promote access to post-abortion care (PAC) services and empower CHPs to raise awareness of these services in their communities.	KII with MSI

Assumption 5.3 The **existing financial resources (MAV funding streams) are adequate to ensure the effective implementation of the Partnership.**	
Indicators **5.3.1** Views of, and percent of surveyed stakeholders/countries who agree the MAV funding streams are efficient and relevant to their contexts. **5.3.2** Documented explanations of the rationale for application of the MAV funding streams. **5.3.3** Percent/ratio of MAV funding stream applied across Partnership countries compared to size and need. **5.3.4** Perceptions of stakeholders on the adequacy of the MAV funding stream to ensure goal achievement in their contexts.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
Despite significant advocacy efforts by UNFPA and partners, and a strong investment case for FP, the Government of Kenya has not disbursed the funds it has committed for family planning under the Compact, so is not eligible for the $1.5M in potential Match Funding that it could access under the Partnership Programme MAV funding stream.	Investment Cases for the Transformative Results in Kenya 2022 – Government of Kenya and ICPD2025

Assumption 5.4 The Partnership has been able to access **appropriate and needed human resources** at the global, regional and national level. [Links to theory of change causal assumption 2.]	
Indicators **5.4.1 Level of effort at global, regional and country levels**, and skill sets (numbers and roles) available across different levels of the organization assigned to support the Partnership. **5.4.2** Perception of staff regarding workload, required staffing levels, and necessary skill sets in relation to the demands of the Partnership. **5.4.3** Perception of staff on turnover (and its consequences) among staff designated to support the Partnership.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
UNFPA Kenya office appears “a bit stretched” (staff, resources) and need to prioritize. Maybe they need some structural changes. They are overwhelmed. They work with other donors/partners, but they are not a large staff	KII with FCDO. October 2024

Assumption 5.5 All **Strategic Objectives work as an integrated system** to efficiently maximize synergies and complementarities, avoiding siloed work. [Links to theory of change causal assumption 4.]	
Indicators **5.5.1** Stakeholders’ views on strategic objectives teams working as an integrated system and examples of synergies being maximized. **5.5.2** Percent of countries who can show how strategic objectives interlink. **5.5.3** Documents evidencing proactive efforts to avoid siloed work	
OBSERVATIONS	**SOURCES OF EVIDENCE**

Assumption 5.5 All **Strategic Objectives work as an integrated system** to efficiently maximize synergies and complementarities, avoiding siloed work. [Links to theory of change causal assumption 4.]	
Re: the SP's objectives and activities being well integrated into the Kenya country programme: Every 5 years, there is a change in national and county government, so there is an ongoing challenge and turnover. Only 4 counties have a budget line for FP now.	KII with MoH SRH technical team. October 2024

EVALUATION QUESTION 6: To what extent is the **Partnership aligned with, complementing, and filling gaps** of other UNFPA initiatives as well as other global initiatives aimed at strengthening access and use of quality reproductive health commodities, while also considering the Nexus approach?					
CRITERIA	Coherence	**AREA OF INTEREST**	Alignment with other relevant internal and external efforts.	**LINKAGES TO THE THEORY OF CHANGE**	Linked to the area of inputs and resources, the pillar of the reconstructed theory of change.
RATIONALE	This evaluation question aims to **assess the extent to which the Partnership is aligned with, complements, and fills the gaps left by other UNFPA as well as other global initiatives aimed at enhancing access to and utilization of quality reproductive health commodities,** with a particular focus on the Nexus approach. Evaluating the synergy between the Partnership and various internal and global frameworks is critical, given the limited resources available for reproductive health/family planning programmes and commodities. The analysis will include examining the linkages between the Partnership and other initiatives, ensuring that while the Partnership addresses mainly the supply dimension and governmental demand for reproductive health commodities and family planning, it also complements the efforts of other actors addressing individual-level demand. First, this question will focus on how well the Partnership aligns with the UNFPA Strategic Plan (2022-2025) and complements other UNFPA initiatives, including UNFPA country and regional programmes and the UNFPA Family Planning Strategy (2022-2030). Second, it will address the Partnership alignment with other GHI, including Gavi and the WHO, considering also relevant bilateral agreements (e.g., USAID), and global initiatives such as the ICPD and the SDGs. Third, this question will assess how effectively the humanitarian-development nexus is considered and integrated into the design and implementation of the Partnership.				

Assumption 6.1 The **Partnership activities are designed and implemented to complement existing UNFPA Country and Regional Programmes**, the UNFPA Family Planning Strategy (2022-2030), and to align with the UNFPA Strategic Plan (2022-2025). [Links to theory of change causal assumption 13.]
Indicators **6.1.1** Extent of alignment between the Partnership objectives and strategies and other relevant UNFPA strategies and programmes **6.1.2** Extent to which non-Partnership UNFPA objectives, strategies and funded programmes address **demand for contraception** as a precondition for the Partnership effectiveness.

Assumption 6.1 The **Partnership activities are designed and implemented to complement existing UNFPA Country and Regional Programmes**, the UNFPA Family Planning Strategy (2022-2030), and to align with the UNFPA Strategic Plan (2022-2025). [Links to theory of change causal assumption 13.]	
6.1.3 Documented examples of **coordinated activities and joint initiatives** between the Partnership and other UNFPA programmes and initiatives. **6.1.4** Perceptions of UNFPA staff and partners on the effectiveness of alignment efforts between the Partnership and other relevant UNFPA initiatives. **6.1.5** Perception of UNFPA representatives and partners on the **complementarities between the Partnership and other relevant initiatives**, including the extent demand is secured from other relevant internal and external initiatives. **6.1.6** Extent to which internal UNFPA documents reflect **demand is being generated** to meet the supply of reproductive health/family planning commodities in targeted countries.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
Family planning commodities are free to the counties. SRH/ family planning commodities should become part of the essential health package and be integrated into health insurance for greater sustainability.	KII with MoH SRH technical team. October 2024
UNFPA works at national level; focus is on policy makers; there is a disconnect with the demand side creation partners at the subnational level. Discussions among the donors who work with the policymakers at national level are determined by the priorities that need to be addressed. At county level, they do not know about the Compact and they see products coming in from different programmes. IPs in counties ensure there is information and capacity building within the county governments. Countries plan comprehensively for their family planning programme, using an HSS approach. The logistics groups get down to the technical details. At health facility level, it is all one team, managing products coming in from different programmes. The partners work in TWGs (which are supposed to meet quarterly), on a broad range of issues. The TWGs tend to focus on the crisis or issue of the day.	KII with FP2030. October 2024
Demand generation is mostly done with new product introductions, which include some training with health workers and county officials on the product. UNFPA works on some demand generation activities with other partners.	KII with CHAI. October 2024
There is a **lack of communication which is population-specific in order to create demand**; this is a missing link to promoting the uptake of the products that are being supplied. To coordinate/complement partner roles, UNFPA led the process of stakeholder mapping and gap analysis to identify the areas supported by the different partners, and those areas that are under-supported or not supported at all. This facilitated resource allocation efficiently and helped to avoid duplication of efforts.	KII with JHPIEGO. October 2024
The SP is **90% aligned with the other UNFPA programme activities and other programmes in country** (the other 10% is about Government): UNFPA holds quarterly meetings with MSI and other partners to monitor progress made, delays, collaborator efforts. These meetings are attended by the Director Generals of NCPD and MoH, and the technical teams from RMNCAH and family planning within MoH and KEMSA. The meetings provide a **platform for learning and knowledge exchange**. It is a NCPD-led process,	KII with MSI-K. November 2024

Assumption 6.1 The **Partnership activities are designed and implemented to complement existing UNFPA Country and Regional Programmes**, the UNFPA Family Planning Strategy (2022-2030), and to align with the UNFPA Strategic Plan (2022-2025). [Links to theory of change causal assumption 13.]	
building ownership and sustainability in Government. There are a lot of lessons learned with other Government depts (e.g. Sports and Youth) in these meetings.	
Partners: **UNFPA organizes and brings partners together to cross-fertilize**, cross-learning. Not just donors, but partners at all levels. UNFPA works with Government entities (e.g. MoH, NCPD, NSDCC) which is good for sustainability and country/Government ownership. Through the Supplies Partnership, UNFPA has **supported the Drop-In Centres** (DICEs) established by ICRH-K in Mombasa, which provide a safe space for female commercial sex workers to access SRH services. These centres receive essential SRH commodities and are staffed by healthcare providers trained through UNFPA capacity-building initiatives. - They have 10,000 SWs across six DICs in their area - He wishes UNFPA could have more programmes to open doors for these women to get trained on other income-generating activities, and school-based activities. They face violence, other problems - The peer educators work from the DICs, provide services and info to the SWs (e.g. GBV, rape care, etc) - UNFPA supports their psycho-social support meetings - including opportunities to get out of sex works. This is a growing cohort; we need to help them get other opportunities (this is not expensive) - Female sex workers generally prefer short-term contraceptive methods such as condoms and injectables. These options are quicker and easier to use. Long-term methods are less favoured due to associated pain or discomfort, although implants and Depo are used in certain cases. - Condoms, the most commonly used contraceptive method among female sex workers, are often in short supply at hospitals, and Depo is rarely available. Lubricants are also frequently unavailable. UNFPA has been **trying to bring on board other partners** (e.g. private sector, manufacturers, distributors, etc) to **complement what the Government can do, and to develop the demand side**. UNFPA is pushing for the **TMA**, to ensure the very poor get products for free, while others can buy them at a reasonable price in non-government outlets. The **gap filled by UNFPA is that of ensuring that the right capacities are available for SRH service provision particularly for female CSWs**	KII with ICRH-K. October 2024
The delays which contribute to commodity stockouts cause disruptions in uptake of especially the new products, which is a setback; resources are invested by various partners for demand creation. There is a need for better coordination between SP and partners e.g., in the implementation of costed plans to avoid duplication of efforts.	KII with In Supply. October 2024

Assumption 6.1 The **Partnership activities are designed and implemented to complement existing UNFPA Country and Regional Programmes**, the UNFPA Family Planning Strategy (2022-2030), and to align with the UNFPA Strategic Plan (2022-2025). [Links to theory of change causal assumption 13.]	
SP is working collaboratively with other partners to amplify advocacy activities.	
Donor support for demand creation activities at community level has decreased. There is no outcry at community level to hold the government accountable in cases of FP commodity stock-outs in health facilities	KII with Options. October 2024
UNFPA supported the increase of the "Talking boxes" across schools in Kibera, which is an innovative practice for allowing adolescents to express their concerns and seek help on topics concerning SRH needs. The information in the "Talking Box" is entered into an internal database then it is coded to produce the evidence report which is UNFPA supported. In light of ensuring a holistic approach, UNFPA supports community engagements with community leaders (Imams, Pastors, Chiefs, Boda Boda riders and male community champions) on the importance of SRH. Through supporting the programmes led by the Polycom girls adolescents are reached with information and referrals to access SRH commodities in safe spaces. Polycom Girls does a due diligence of health facilities for them to determine which health facilities would be safe for adolescents to access SRH services. UNFPA supports holiday forums, by providing transport reimbursements, meals and refreshments. These holiday forums are also a kind of check-in that also accommodate those students that could not be reached within their respective schools UNFPA also supports the mentorship programme run by Polycom girls. These peer-to-peer mentors are in charge of taking over once they complete school as they wait to go for tertiary studies UNFPA also supports advocacy events on key days such as the Day of the African Child and the International Day of the Girl	KII with Polycom Girls. November 2024
Demand: Women are offered a choice of products, they choose their preferred one, are trained, and then don't get it (and are either forced to take another method or find it elsewhere). This negates their ability to really choose. Health Workers and health facilities do the demand generation, information to clients. When there is then no stock, "this takes us backward" and this "is not her choice" (e.g. if she has to shift temporarily to another method that is in stock). (The HWs counsel the woman on other methods, offer to provide it to her, then remove it (e.g. the IUD or implant) when the preferred (e.g. DMPA injectable) stock comes in. **Women beneficiaries:** There was consensus among the women that there were **knowledge disparities** on family planning methods between the urban-based women and those who reside in rural areas; additionally, the CHPs had **limited information regarding the family**	Narok County - Ololulunga sub-county mgmt. and HF visit (and CHPs and FGD with women beneficiaries). Narok county. November 2024

Assumption 6.1 The **Partnership activities are designed and implemented to complement existing UNFPA Country and Regional Programmes**, the UNFPA Family Planning Strategy (2022-2030), and to align with the UNFPA Strategic Plan (2022-2025). [Links to theory of change causal assumption 13.]	
planning products. There were plenty of myths circulating about family planning within the community which were influencing adoption of family planning methods. They reported that more counselling was needed for adoption of family planning by more women. To generate demand. 1 woman reported that she had experienced side effects from using an family planning method and had subsequently discontinued and hadn't visited the health facility again; there were no CHPs visiting her area so she had no source of verifiable information. The women also reported that **demand for family planning was also adversely affected** when some spouses prohibited the women from seeking family planning due to mistrust, and socio-cultural norms where having many children was associated with high community status for the men. The women also shared that the education system was also a barrier to adolescents accessing SRH because of spreading disinformation regarding family planning methods being potentially harmful to adolescents. This was cited as one of the contributors to high rates of teen pregnancies in their communities	
The SP under the **10th UNFPA Kenya Country Programme** (USD 35M?) Cycle is different from the previous country programme. The previous country programme had the MoU, the new country programme has the compact. The Country Programme has targets for each output, with 5 CP outputs – Regulation & policy, Quality SRH, Harmful practices & GBV, Adolescent SRH, Evidence for programming. Humanitarian support cuts across all 5 of these areas). The Supplies Partnership cuts across all the outputs.	KII with UNFPA SRH/FP specialist. November 2024
SP is integral to UNFPA Country Programme and needs to continue. UNFPA funds are minimal vs. the needs, but catalytic. **Data quality and use for the programme has been inadequate**. The DHS was delayed for the national census, then Covid. They are starting to train, with MoH, on data quality and use (with KEMSA and others), with the second batch of trainees starting next year. UNFPA through the Partnership has **collaborated with organizations** such as the Red Cross in ensuring that family planning commodities reach those rights holders in **humanitarian contexts**. Through the SP, 1,214,741 clients in humanitarian settings have accessed family planning services. Through the SP, 103 Humanitarian Health Care Workers from Red Cross and county health teams were trained in the iLMIS . For those rights holders in areas that culturally are not receptive to family planning, there have been some challenges faced in meeting those needs.	UNFPA rep and key staff meeting. October 2024

Assumption 6.2 The Partnership **fills critical gaps and complements other relevant GHI** such as Gavi and World Health Organization.
Indicators

Assumption 6.2 The Partnership **fills critical gaps and complements other relevant GHI** such as Gavi and World Health Organization.	
6.2.1 Extent to which situation analysis and planning documents identify gaps in support of reproductive health commodities as an element in global public health. **6.2.2** Extent to which the Partnership strategic documents map out activities in relation to other GHI to identify complementarities and gaps, as well as areas of potential overlap or duplication. **6.2.3** Key informants experience and opinion regarding Partnership activities at country level demonstrating complementarities with other donors' programmes and activities. **6.2.4** Documented examples of the Partnership design incorporating or highlighting complementary activities building on, or contributing to other development partners' investments in reproductive health commodities and their distribution **6.2.5** Stakeholders perception of the Partnership role in the global health landscape and its contribution to filling gaps.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
Using schools as an entry point for reaching adolescents with ASRH is a good example of integration efforts; however, there is **poor coordination between the MoH and Ministry of Education (MoE) to integrate SRH information in schools**. This is a missed opportunity to reach youth with these SRH/ family planning commodities.	KII with NAYA. October 2024
Kenya is **mainstreaming the agenda for the provision of adolescent and youth friendly services** (AYFS) within health facilities. This has been a good way to promote access to ASRH. However, this access has inequalities and inequities because it is more readily available for urban-based AYPs; **access is still a challenge** for rural-based AYPs where there are limited health facilities and healthcare workers. Disparities in literacy levels between the urban vs rural-based AYPs also influences access to/ demand for ASRH services	KII with NAYA. October 2024
Partners are not all coordinated in country, especially local Governments (county level). They "do things in counties without the MoH even knowing about it." County Governments are independent and can sign MoUs with partners (since Government power was devolved). They have DPHK: Development Partners for Health in Kenya, which include the major donor organizations for health – e.g. WHO, WB, USAID, etc. With one implementing partner for each donor. **There is better coordination now**, with TWGs at national level bringing key stakeholders together.	KII with MoH SRH (tech team interview. October 2024
The health facility has an **adolescent and youth friendly space** to provide ASRH, along with IEC materials targeted at the adolescents and youth. However, they lack skills to provide adolescent and youth friendly services and address the SRH needs among the adolescents and young people. UNFPA and MSI have trained the CHPs in communications to ensure that they pass accurate information to community members to mobilize and help them to make informed decisions about taking up NLU family planning. CHPs also provide referrals to community members to the facilities where they can obtain the preferred services. MSI has also participated in public engagement activities and forums The CHP+BTL champion visits 33 households monthly and attends different community forums where she disseminates information using fliers; she also uses social media channels as a communication channel. The VSC beneficiaries are mobilized	KII with Embakasi HC and team (virtual KII from MSI). November 2024

Assumption 6.2 The Partnership **fills critical gaps and complements other relevant GHI** such as Gavi and World Health Organization.	
as champions in their communities to create awareness; with support from the MSI team they conduct sensitization activities in their community health units The MSI advocacy team is planning to train more FP champions across the spectrum of family planning methods. MSI builds the skills of the CHPs in interpersonal communication to promote behaviour change in the community. Additionally, they will support the county health management teams to conduct trainings The fluctuations in stocks availability e.g., DMPA-SC interferes with uptake after the demand has been created within the community, and clients visit the facility but cannot obtain the family planning product.	

Assumption 6.3 The Partnership effectively integrates the humanitarian-development nexus, ensuring that short-term emergency activities are aligned with long-term development goals.	
Indicators **6.3.1** Extent to which the Partnership planning and approval documents, as well as strategic frameworks and operational plans incorporate humanitarian and relevant development objectives, with clear references to the humanitarian-development nexus. **6.3.2** Extent to which regional and country-level Partnership implementation plans clearly include provisions for interventions to address humanitarian and emergency needs. **6.3.3** Extent to which humanitarian response plans in Partnership countries include specific linkages and strategies to long-term development goals. **6.3.4** Experiences and opinions of UNFPA staff partners, beneficiaries and local authorities regarding the effectiveness of Partnership interventions to humanitarian and emergency needs while focusing on long-term development goals.	
OBSERVATIONS	**SOURCES OF EVIDENCE**
Humanitarian: There are refugee camps in some counties in Kenya. There was a humanitarian assessment review on PAC and family planning done recently (reporting coming out soon). MSI-K (an SP implementing partner) will learn a lot from this on access to SRH in these humanitarian settings. Kenya Red Cross and UNHCR have clinics in the camps and serve refugees and the host communities with health care, but not usually family planning. MSI works with the disaster risk management team to help get commodities.	KII with MSI-K. November 2024
Kenya Red Cross Society is a **key IP of UNFPA for humanitarian settings**, facilitating distribution of kits and other commodities to ASAL areas and other hard-to-reach areas, refugee camps and disaster areas	KII with Red Cross KII. November 2024
Advocacy is a new space for This Ability trust. Communication materials (banners) were printed with the funding from UNFPA. A documentary on SRH was made with funding from UNFPA through the Partnership. They have also done online meetings, webinars, trying to identify the key actors in the MoH system to advocate for SRH/ family planning. Effort to integrate gender, disability, technology with PWD to self-register; **sensitizing health workers to integrate women with disabilities through** webinars, policy briefs, meetings.	KII with This Ability Trust (group interview). November 2024

Assumption 6.3 The Partnership effectively integrates the humanitarian-development nexus, ensuring that short-term emergency activities are aligned with long-term development goals.	
Through the Partnership, organizations such as the RHNK have been able to **respond to humanitarian needs for SRH service**. With the information available on the iLMIS, they were able to facilitate redistribution from Nairobi county to other parts of the country in humanitarian contexts. UNFPA has **supported the RHNK in organizing the A&Y SRH conference** in collaboration with the government and other stakeholders. They interact through trainings on advocacy, ensuring that A&Y understand how to seek for SRH services. UNFPA provides support in the establishment of youth friendly spaces.	KII with RHNK KII: November 2024
As a catalytic fund, SP cannot support equipment, electronics, brochures, t-shirts, posters and other demand generation materials. They do advocacy and communication, and promote visibility of SRH/ family planning issues through job aids, training materials, social media, information materials for advocacy with religious leaders, etc. UNFPA relies on development partners and others for **demand generation efforts**. Re: stakeholder **mapping**: it is dynamic. At the beginning of 2024, UNFPA wanted to map partners contributing to Country Programme #10 (aiming for 0 unmet need, 0 maternal deaths, 0 GBV) including SP partners. They found there was a gap on permanent methods, **so MSI-Kenya was added as an Implementing Partner.** The last IPPF affiliate had "governance challenges" so that partner was removed (and dissolved by IPPF), and they now work with RHNK as a collaborator (and trying to make them an IP).	KII with UNFPA CO SRH/FP specialist. November 2024

Annex 2: Persons interviewed in kenya

Organization	Position
UNFPA Country Office	Country Representative – Introduction, leading questions
UNFPA Country Office	Discussion with Representative and SRH/FP Team: Country Representative; FP/RHCS Specialist; M&E specialist; Finance and Operations; Population and Data Specialist; ASRH & Youth Assistant; Operations Assistant; SRH Youth Advisor; Logistics, Programme assistant; Executive assistant; Administration Assistant; Communication and Advocacy Specialist; International Operations Manager; Clerk
National Council for Population and Development (NCPD) (Implementing partner)	Director of Public Education; National Advocacy Lead and FP Focal Point; Commodity security for RH; UNFPA Focal Point
Network of Adolescents and Youth of Africa (NAYA) (Implementing partner)	Executive Director
Ministry of Health (Implementing partner)	Director of Family Planning; Director of SRH
FP2030	Managing Director, East and Southern Africa Regional Hub
KEMSA (Implementing partner)	Entire team: CEO; Project Director; ICTM; Ag. DMCP; DCS; Ag DFS; Ag. DLS; Director HR and administration
	iLMIS demo and discussion
JHPIEGO (Collaborator)	Technical Advocacy Advisor
FCDO – UK Government Foreign, Commonwealth and Development Office (Development Partner, Multilateral donor)	Team Lead for Health; Programme Officer for Health
Options Consultancy (Collaborator)	Director, East Africa
Population Services Kenya (PSI-K) (Collaborator)	CEO; Director, Social Enterprise; Director, DESIP/Reproductive Health; RH/FP Specialist, DESIP Programme
Clinton Health Access Initiative (CHAI) (Collaborator)	Programme Manager, SRH; Analyst & seconded to RHSC
In Supply (Collaborator)	Kenya Practice Leader; Advisor, Supply Chain; Quality Implementation and Capacity building
Nation Media Group (Collaborator)	Editor & Podcast Host, Nation Media Group; Strategy & Partnerships, Nation Media Group Foundation
International Centre for Reproductive Health – Kenya (ICRH-K)	Country Director; Senior Programme Officer for MH & UNFPA FP
	Beneficiaries: Three FSW peer educators (Mombasa) (by Zoom)

Organization	Position
(Implementing partner)	
This Ability Trust (Implementing partner)	Operations Trustee; Finance assistant; Media; ICT officer; Programme officer; Skills project office); Finance officer; Advocacy officer; Finance Manager; Legal Trustee
Bill and Melinda Gates Foundation (BMGF) (Development Partner, Multilateral donor)	Senior Programme officer – FP, MNCH, PHC Africa
Nairobi County – Kibra DO Health Centre (Implementing partner)	Sc-PHN Kibra; sub county depot manager; sub county community strategy
	Beneficiaries: two mothers on FP
	Focus Group Discussion with ~10 Community Health Promoters (CHPs)
Narok County (Implementing partner)	Meeting at the director's office: Director of Health; County Pharmacist; CRHC - Coordination, SRH services for county
Narok south sub-county (Ololulungo)	Meeting at the sub county level: SCMOH; SCRHC; SCCO; Muli Sub County Pharmacist; Nursing Officer Incharge
	FGD with beneficiaries: women who access FP services at the health facility (8-10)
DKT Healthcare (virtual) (Collaborator)	National Sales Mgr; Regional Procurement & Logistics Mgr
Reproductive Health Network Kenya (RHNK) – IPPF Affiliate (Collaborator)	Executive Director; In charge of commodities
Polycom Girls (Implementing partner)	Project Officer; Communications and Male Engagement Officer; beneficiary, mentor; head of pads programme
Marie Stopes Kenya (MSI) (Implementing partner)	Head, Pillar 1 & UNFPA focal point; Senior Programme Manager; new Country Director; Head of procurement; Programme Assistant, Pillar 1; Procurement & Supply Chain; Finance, Procurement, IT; Technical Services Director
Embakasi Health Centre, Embakasi sub-county (virtual meeting, from MSI-K conference room)	County RH Coordinator, MSI-K focal point, former in-charge at Embakasi HF; supervisor for HSS, tracking, advocacy for Nairobi; Baringo, Garisa counties; nurse-midwife, Embakasi east;nurse trained in VSC; RH clinical officer & surgeon, NBO county; MSI QA advisor & trainer on voluntary surgical contraception; MSI-K Advocacy and FP officer; Facility in-Charge, nurse/midwife; vasectomy beneficiary & champion; bitubal ligation champion and CHP, Embakasi health centre
Kenya National Commission on Human Rights (Collaborator / Implementing Partner soon)	Project Officer supporting migration & human rights; Senior Project Officer, focal point for transitional justice; Gender focal point, senior human rights officer, specialist in access of vulnerable groups to SRH
USAID (Development Partner, Multilateral donor)	Project Management Specialist, MCH FP & RH for USAID for Eastern Africa for USAID Health, Population, Nutrition (HPM) Office
Ministry of Health M&E Dept (Collaborator)	Ministry of Health Monitoring & Evaluation officer

Organization	Position
Kenya Red Cross Society (Implementing partner)	Lower Eastern region; Supply chain; Logistics & Warehousing; Warehousing support; Lower Eastern region; Health & Nutrition dept
UNFPA Country Office	One-on-one virtual KII with FP/RHCS Specialist
UNFPA Country Office Team debriefing	Country Rep, Pilar de la Corte Deputy Rep, FP/RHCS Specialist, SRH Youth Advisor; M&E specialist, Population and Data Specialist, Humanitarian Specialist; Logistics, Programme Assistant, Administration Assistant, Finance and Operations; International Operations Manager, Clerk; new humanitarian staff member

Annex 3: Bibliography

UNFPA SUPPLIES Partnership Mid-Term Evaluation 2021-2024 – PowerPoint presentation by UNFPA Country Office to EHG evaluation team, Oct 28, 2024.

Kenya Country Compact (signed in 2024)

Signed Compact of Agreement between the Government of the Republic of Kenya and the United Nations Population Fund (UNFPA) for the UNFPA Supplies Partnership. Kenya Country Compact (first Compact signed, in 2023)

Last Mile Assurance Assessment report, 2023 - Kwale & Kilifi Counties Dissemination on LMA Spot Check Findings, and FP Supply Chain Management Orientation. April 2023

LMA Spot Check report - May 2022.

UNFPA (2022). Sustainability Readiness Assessment Tool Kenya.

UNFPA (2023). Kenya Country Narrative Report 2022.

UNFPA Supplies Partnership Annual Report 2022 Kenya.

UNFPA (2020). Welcome to the UNFPA Supplies Partnership 2021-2030 - Uniting for transformative action in Family Planning and Maternal Health.

UNFPA Supplies Partnership: Meeting on the Inception Phase for the Mid-Term Evaluation - PowerPoint Presentation by Supplies Partnership team to evaluation team May 7, 2024.

Government of Kenya (2022). Investment Cases for the Transformative Results in Kenya 2022.

Kenya Ministry of Health (2022). Family Planning Commodities Forecasting and Supply Planning (FASP): Technical Report.

Kenya Ministry of Health (2023). Family Planning Commodities Forecasting and Supply Planning (FASP) (2023-2026) Technical Report.

MoH Family Planning Commodities Stock Status Report for end of February 2023.

UNFPA (2022). UNFPA Supplies Budget Allocation Letter Kenya 2022.

UNFPA (2022). Country Programme Document for Kenya 2022-2026.

Kenya Ministry of Health (2022). Family Planning Commodities Forecasting and Supply Planning: Technical Report.

Kenya National and Country Health Budget Analysis, FY 2020/21

Kenya Health Accounts FY 2015/16: 2019 Update

CHAI Kenya Repository - Jan 2025 - https://chaiportal.org/program/details?summary=30

Kenya | Employment Tax | The Social Health Insurance Fund (SHIF) - Oct 22, 2024 - https://vialtopartners.com/regional-alerts/kenya-employment-tax-the-social-health-insurance-fund-shif

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