Government of Kenya and UNFPA Programme of Cooperation

Good Practices and Evaluative Evidence from the Implementation of the GOK/UNFPA Programme of Cooperation

A Synthesis of the Country Programmes Annual Reports and Evaluations

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Foreword

This publication forms one of the first attempts by a UNFPA Country Office (CO) to document good practices from the implementation of the Country Programme of Cooperation in a country of UNFPA-support. The documentation of good practices and related evaluative evidence from the programme interventions presents a great opportunity for the Country Office and counterpart implementing partners to reflect on what works, facilitating factors and challenges which need to be looked at as lessons learned to shape future Programmes' desired outcomes and effectiveness.

The motivation to document this Kenya Country specific good practices and evaluative evidence as well as lessons learned presented separately in a summary of the Progress Report of the 9th Country Programme (9CP) was mainly inspired by lessons from the three corporate synthesis of lessons learned and good practices for corporate learning starting with selected country's evaluations conducted in the period 2010 - 2013[1]. In addition to these global exercises by the UNFPA Evaluation Office, Regional Offices or Headquarters (HQ) Divisions have also undertaken similar exercises which have proved quite resourceful as reference materials for this publication. These include: Best Practices and Lessons Learned in Humanitarian Settings - Africa Region[2]; Good Practices and Lessons Learned on Sexual Reproductive Health (SRH) and Gender-based Violence (GBV) in Emergency Settings in Latin America and the Caribbean[3]; Ten Good Practices in Essential Supplies for Family Planning and Maternal Health by the UNFPA HQ Commodity Security Branch[4]; and more recently, the Compendium of Good Practices during the COVID-19 Pandemic – Ensuring SRHR for Women and Girls with Disabilities (UNFPA and Women Enabled International (WEI))[5]

The analysis of the Kenya Country Programme Reports for this publication therefore borrows heavily guidance and narratives from the above stated works among others referenced. The intention is that based on the rich documented lessons learned and good practices from the global perspective, the COe can also come up with good practices and lessons learned (and challenges) experienced in the implementation of the Kenyan Programme of cooperation for further strengthening of Programmes. The experiences documented blend very critical aspects of situations that Programme Cycles go through in many countries. These include programme implementation in situations of deep rooted cultural norms that perpetuate harmful practices such as FGM, GBV and early (girls) marriages; unforeseen emergencies such as experiences during the Covid-19 pandemic; and the dwindling Official Development Assistance (ODA) as the country moves to "middle income" status.

In view of these three overarching challenges, the review of the Country Programme Reports points to the critical roles played by strategic partnerships (public/private, Government/Non-Governmental, community-level leadership [Societal and Religious] as well as women's and youth networks); increasing importance of encouraging, supporting and nurturing innovations (including digital-based) especially

[1] https://www.unfpa.org/admin-resource/lessons-learned-unfpa-country-programme-evaluations
[2] https://esaro.unfpa.org/sites/default/files/pub-pdf/UNF-%20Brochure%20ANG_150x210.pdf
[3] https://lac.unfpa.org/sites/default/files/pub-pdf/UNFPAenglish.pdf
[4] https://www.unfpa.org/sites/default/files/pub-pdf/Ten%20Good%20Practices%20Essential%20Supplies_GPRHCS_web.pdf
[5] https://www.unfpa.org/resources/compendium-good-practices-during-covid-19-pandemic

with active participation by women and youth; and mobilization of these groups in harnessing and leveraging of available resources especially through locally-based initiatives.

The CO acknowledges contributions of the implementing partners not only in providing substantive reports used to analyse and extract the good practices, lessons learned and challenges but also providing valuable inputs to the publication especially during and after the 9CP Progress Workshop; the CO's own Programme Managers; and the Consultant who provided the initial draft and later collated the inputs provided by the Stakeholders.

It is hoped that this is the beginning of a process that will continuously be reviewed during (and at the end of) every Programme Cycle of which will also be enriched by peer reviews from the Region. This will help in refining and improving on future documentation of best practices, experiences and lessons learned in strengthening Government, UNFPA and other partners' supported programmes for the intended achievement of the Government's priorities while contributing to the UNFPA three transformative results – **ending preventable maternal deaths, ending unmet need for family planning**, and **ending gender-based violence and all harmful practices** – and hence the ICPD PoA.

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Acronyms

AIDS:	Acquired Immune Deficiency Syndrome
ANC:	Anti-Natal Care
ASD:	Age of Sexual Debut
AWP:	Annual Work Plan
CHAI:	Clinton Health Access Initiative
CO:	Country Office
CHVs:	Community Health Volunteers
CHW:	Community Health Workers
CPR:	Contraceptive prevalence rate
CP:	Country Programme
CSO:	Civil Society Organizations
DAC:	Development Assistance Committee
EmONC:	Emergency Obstetric & Newborn Care
ESARO:	East and Southern Africa Regional Office
ETE:	End-Term Evaluation
FBOs:	Faith-Based Organizations
FP:	Family Planning
FPRJC:	Feminists for Peace, Rights and Justice Centre
GBV:	Gender Based Violence
GDP:	Gross Domestic Product
GoK:	Government of Kenya
HAK:	Health Association Kenya
H6:	Partnership among UNAIDS, UNICEF, UNFPA, UN Women, WHO, and World Bank
HIS:	Health Information System
HIV:	Human Immunodeficiency Virus
HQ:	Headquarters
IP:	Implementing Partner
JP:	Joint Programme

KDHS:	Kenya Demographic Health Survey
KEMSA:	Kenya Medical Supplies Authority
KHF	Kenya Healthcare Federation
LMIS:	Logistics Management Information System
MMR:	Maternal Mortality Ratio
MNH:	Maternal and Newborn Health
MoH:	Ministry of Health
MTP:	Medium Term Plan
NHIF:	National Hospital Insurance Fund
ODA:	Official Development Assistance
OECD:	Organisation for Economic Co-operation and Development
PMTCT:	Prevention of Mother to Child HIV Transmission
PPP:	Public-Private Partnership
PRSP:	Poverty Reduction Strategy Papers
RMNCAH:	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SDGs:	Sustainable Development Goals
SRHR:	Sexual and Reproductive Health and Rights
TBAs:	Traditional Birth Attendants
TOR:	Terms of Reference
UN:	United Nations
UN Women:	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS:	Joint United Nations Programme on HIV/AIDS
UNCT:	United Nations Country Team
UNDAF:	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA:	United Nations Population Fund
UNICEF:	United Nations Children's Fund
USAID:	United States Agency for International Development
WEI:	Women Enabled International
WHO:	World Health Organization

Introduction

Globally, and by extension through its Country Offices, UNFPA is committed to evidence-informed decision making, improving learning and sharing knowledge. Thus evaluations and synthesis of the resulting information are vital tools for UNFPA to understand what works clearly, and why, enabling the Organization to deliver more and better, hence living true to the spirit of leaving no one behind. In this regard, the UNFPA Kenya Country Office would like to have a documented reservoir of resources which can be used to strengthen accountability for results, ensure evidence-based decision-making, and identify key lessons learned for improved programme planning and implementation in Kenya.

The first corporate synthesis of evidence for learning was supported by the Evaluation Office leading to the production of "Lessons Learned" from UNFPA Country Programme Evaluations 2010-2013. The second was undertaken – representing a continuation of the effort by the Evaluation Office to periodically undertake syntheses – involving a review of the findings from 26 country programme evaluations conducted between 2014 and 2015[6]. The results from both exercises contributed immensely to the mid-term review of the UNFPA Strategic Plan 2014-2017. Thereafter, the Evaluation Office set scheduled synthesis of learning regularly, in order to continue to strengthen the use of evaluation to advance the implementation of UNFPA strategies and policies, as well as internationally agreed development goals, including the Sustainable Development Goals (SDGs).

The current exercise mirrors to a global one undertaken in 2019 by the UNFPA Evaluations Office - A synthesis of UNFPA country programme evaluations.[7] In this case, the analysis drew on 57 UNFPA country programme evaluations conducted from 2012-2018 to identify good practices around the organization's three transformative results – **ending preventable maternal deaths, ending unmet need for family planning**, and **ending gender-based violence and all harmful practices**. Overall, the exercise identified common good practices that can accelerate UNFPA and partners' efforts to achieve the organization's these transformative results. The good practices captured from the analysis aptly highlighted the different factors that have contributed to the Fund's programmatic effectiveness as well as those that have limited or constrained progress.

In a similar fashion, this exercise is drawing the synthesis from Evaluations, Annual Reports, Studies and other Reports that have been generated in the course of implementing the 9CP, supporting advocacy for policy implementation at the national level and mobilizing resources for capacity building and service delivery interventions in the selected Counties. Thus from synthesizing and analyzing these Reports, this document highlights how and to what extent programme interventions in the various Counties have generated valuable good (or promising) practices with supportive evidence which can be used in future programmes for effective UNFPA contribution to the GOK and other partners' efforts in addressing national priorities as well as contributing to the UNFPA Transformational results.

The guiding principle is that the revised UNFPA Evaluation Policy 2019 sets out to improve and strengthen accountability, evidence-based decision-making and learning at UNFPA by articulating clearly that the design of new country programmes must be informed by an adequate and relevant body

[6] https://www.unfpa.org/sites/default/files/admin-resource/Synthesis_study_FINAL.pdf

[7] Getting to zero: Good practices from synthesis of UNFPA country programme evaluations (https://www.unfpa.org/admin-resource/getting-zero-good-practices-synthesis-unfpa-country-programme-evaluations)

of evaluations, including country programme evaluations. Country programme evaluations are expected to be conducted at least once in every two programme cycles, unless the quality of the previous country programme evaluation was unsatisfactory and/or significant changes in the country context have occurred. However, it is critical that evaluative evidence is used to improve programme design and evaluation, thus the need to compile a compendium of evaluative evidence based on the most recent centralized and decentralized evaluations.

For this particular case, it is anticipated that the design of the 10th Country Programme will need to be informed by the good practices and lessons learned during the 9th Country Programme as well as the related outcomes of recent evaluations that have been undertaken in the Country as well as those undertaken globally which provide valuable lessons for the Country Programme implementation.

Context

To put in more perspective the significance of this exercise, it is imperative to highlight some of the key population dynamics that have a bearing on UNFPA collaboration in Kenya. Based on the 2019 Kenya Population and Housing Census, Kenya's population was recorded to be 47.6 million with an inter-censual population growth rate of 2.3 percent comprising an increase of about nine million over the 38.6 million enumerated in 2009. Even with a decrease from 43 per cent to 39 percent of the population below 15 years of age, Kenya's population is still structurally youthful when this cohort is considered alongside the adolescent and youth cohort (10-24 years) which comprised 26 percent at the time of the count.

Over the years, there has also been the experienced decline in fertility from 5 children per woman in 2003 to 4 children in 2014. This decline could positively be seen in line with the increase in contraceptive use of which for example contraceptive prevalence rate (CPR) for married women rose from 39.3 percent in 2003 to 58 percent in 2014. Positive trends have also been recorded in such indicators as infant and under five mortality rates which have declined substantially over the last two decades possibly linked to the notable increase in health service deliveries (linked to infant/child and maternal survival rates) which improved from 40 to 61 percent over the same period.

However, the country is still faced with a myriad of challenges in regard to these indicators including: a youthful population as indicated above (39 percent aged below 15 years and 26 percent aged 10 – 24 years) which is bound to sustain a high fertility rate (with Adolescent Birth Rate of 96 births and overall total fertility rate being 3.9 per woman); There is still scope to increase contraceptive prevalence rate and reduce the unmet need for family planning currently at 64 percent (ant method) and 15 percent respectively.

In regard to challenges in the gender equality dimension, prevalence of FGM among women and girls, 15-49 years stands at 21 percent while gender-based violence prevalence is estimated to be 44 percent. In addition, age at first marriage is also a contributory factor in this area with about 4 percent of the women aged 20 – 24 reporting having been married before attaining the age of 15 years and 23 percent of the same age group having been married before attaining the age of 18 years.
It is against this background that the 9CP, like the previous related CPs, was formulated to respond to national priorities such as those articulated under the Social and Thematic Pillars of the Third Kenya Medium-Term Plan (2018-2022), including the Government's 'Big Four' Agenda. The CP is part of the

United Nations Development Assistance Framework (UNDAF) for Kenya (2018-2022) – within the framework of "Delivering as One" – and in line with Goals 3, 4, 5 and 17 of the UN 2030 Agenda for Sustainable Development and Aspiration Areas 1.2, 1.3, 6.1 and 6.2 of the Africa Union Agenda 2063. UNFPA therefore accords the highest priority to strengthening accountability to the people served, collaborating partners and its benefactors.

Through the operationalization of the 9CP, UNFPA has been supporting advocacy for policy implementation at the national level and mobilizing resources for capacity building and service delivery interventions in some Counties which were selected based on their level and performance of key indicators including those enumerated in the Context section above. The programme is implemented in coordination and collaboration with line ministries, United Nations and other partners working in the selected Counties.

The specific Counties are Homabay, Kilifi, Narok, Kitui, Nairobi (focusing in the Kibera informal settlement), Turkana (in collaboration with other UN Agencies as a "Delivering as One County), Mandera, Migori, Marsabit, Wajir, Isiolo, Lamu under the UN H6 Joint Programme on Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) which ended in December 2020); and the UNFPA-UNICEF Joint Programme on Female Genital Mutilation (FGM) which is implemented in Baringo, West Pokot, Elegyo-Marakwet, Narok, Marsabit and Samburu counties.

Purpose of the Exercise

The main purposes of the synthesis as given in the terms of reference (TOR) for the exercise, are to review and synthesize Country Programme generated reports including evaluations, annual reports and other related studies undertaken, and bring out good practices and evaluative evidence which highlight the different factors or initiatives that can contribute to programmatic effectiveness as well as those that need to be addressed in order not to constraint the progress being made in the various supported programmes. Thus from synthesizing and analyzing these Reports, this document highlights how and to what extent programme interventions in the various Counties have generated valuable good (or promising) practices with supportive evidence which can be used in future programmes for effective UNFPA contribution to the GOK and other partners' efforts in addressing national priorities as well as contributing to the UNFPA Transformational results in Kenya i.e. **ending preventable maternal death**; **ending unmet need for family planning**; and **ending gender based violence and harmful practices against women and girls**.

Methodology and Scope of the Analysis

The methodology applied was purely desk review of secondary data from the available documents mainly the 8th CP and the Joint Programme (JP) on RMNCAH evaluation Reports as well as the 9th Co Annual Reports as well as some of the UNFPA global evaluations where Kenya was part of the Countries included.

Definition of Terms

The following terms form the core focus of this Report. Their definitions are mostly based on the definitions presented in many of the UNFPA publications on evaluations. In some cases, however, explanations have also taken into account definitions found in publications by other agencies such as WHO, UNDP and the Organisation for Economic Co-operation and Development (OECD)/Development Assistance Committee (DAC).

Good practices	Programmatic approaches that have proven (through an analysis of evidence) to reliably lead to a desired result. A "good practice" could be related to the implementation of a programme, a project, a policy, a legislation, a strategy or even an activity. Although some write-ups use "best practices", caution is now being taken in labelling a practice as "best", which might suggest a strong claim about its "universal applicability and relevance for all". Therefore, for purposes of this analysis we will adopt the "good practices" angle.
Evidence	Information, facts, data, examples (or a combination of these) used to support a point being made.
Evaluative evidence	Refers to information or data indicating qualitative and quantitative values of development processes, outcomes and impact, derived from multiple sources of information and compiled in an evaluation exercise. It helps in using the information generated from experience to influence the way in which appropriate policies and programmes /projects can be developed, and/or the way in which they can be managed.

In addition to these definitions, sifting out and statement of the good practices and supportive (evaluative) evidence also took into consideration following:

- **Relevance:** Consistency with the CO programme activities, and outputs/outcomes and national policies and programmes.
- **Replicability:** Potential for replication (with appropriate modifications as may be required) to future programmes
- **Impact:** Difference made to the beneficiaries and ability to inform future programme design and have established baseline against which progress can be measured
- **Sustainability:** Durable solutions with possibility of building local capacities and opportunities possible to sustain medium and long-term aspirations of what the programme has initiated.

Limitations

The scope of the synthesis is limited to the information obtained from two main country evaluations – the 8th CP Evaluation Report and the H6 Joint Programme on RMNCAH – as well as the 2019 and 2020 CO Annual Reports and, in some cases, reports where Kenya was included in the UNFPA global evaluations. A major source of limitation in this case is that each of these evaluation exercises had different set of questions, or focus of the evaluation, while the annual reports mainly report what had been achieved for the respective year based on what was planned. In addition, the information used is wholly based on secondary data.

Good Practices and Evidence Generated from the Reviewed Documents

Based on the definitions described previously, the synthesis presents what has been identified as good practices including a brief overview illustrating with evaluative evidence how a particular programmatic approach successfully contributed or has the potential to contribute to the achievement of the UNFPA-supported programmes and eventually the transformative results.

Good Practice 1 - Strategic partnerships:

Multi-sectoral and multi-institutional approaches to galvanize the comparative advantage of diverse sectors in service provision and leveraging of available resources

Different actors and sectors with linked interventions at different levels have the potential to generate conditions for issues like SRH issues to be understood and addressed from different angles, depending on the context and the interactions between relevant cultural, social and political factors. It allows for the optimization of existing resources and RMNCAH was a good example of a collaborative initiative between the Government of Kenya and UN H6 partners (UNAIDS, UNFPA, UNICEF, WHO, UN Women, and the World Bank) providing valuable lessons for integrated SRH interventions, particularly to reduce maternal morbidity and mortality and teen pregnancy. The programme targeted the six most affected counties (Mandera, Wajir, Lamu, Isiolo, Marsabit and Migori) that accounted for up to 50% of the maternal and newborn mortality burden and lagged behind in all other RMNCAH indicators when compared to other counties.

It is a fact that the quality of care especially on issues related to maternal health, depends on the availability and accessibility to physical infrastructure, human resources, knowledge, skills hence capacity to deal with both normal pregnancies and complications that require prompt, life-saving interventions. Improving the overall quality of care in health facilities has been recognized as an important focus in the quest to end preventable mortality and morbidity among mothers and newborns.

The CO through the RMNCAH programme engaged in extensive capacity development (including training in EmONC, focused antenatal care and family planning) interventions to expand access to improved quality of maternal and newborn health (MNH) care and services in the focus counties. This was further supported by health facility infrastructure improvement and procurement of assorted lifesaving MNH equipment to support the referral system part of which constituted contributions from other agencies' interventions through their components of the JP hence ensuring a combined effort to strengthen the health systems' approach for enhanced provision of the integrated services.

The other notable benefits of implementing the programme activities jointly include each partner being in the know of what other partners are doing right from the planning phase with joint planning through the implementation phase with joint annual planning, reviews and monitoring visits. This approach also ensured that national counterparts especially the counties' level do not feel "overburdened" with almost similar exercises from UN partners coming at different times. The use of technical expertise based on the mandate of each of the UNH6 partners ensured minimizing duplication of efforts and hence efficient utilization of programme resources. Additionally, the programme leveraged on the support of other programmes implemented by UN H6 and other agencies – with funding from participating agencies core resources or development partners and also of public–private partnerships such as the Private Sector Health Partnership Kenya.

There is also the element of a multi-pronged approach on advocacy by the partner agencies. If undertaken in a coordinated manner in terms of messaging and presentation, it can contribute to influencing demand and uptake of information and services as well as shaping policy development and implementation at national and county levels.

Box 1: Examples of the successes attributed to the combined efforts in the JP implementation in the Programme Counties

- *Proportion of women attending four ANC visits increased from an average of 43% to 57%*
- *Skilled delivery increased from 50% to 65%*
- *Proportion of Levels 2 to 4 health facilities providing BEmONC services increased from 53% to 65%*
- *Influencing key Policies and Plans development such as:*
  - *The GBV policy in Migori County,*
  - *The ASRH action plans*
  - *Costed Implementation Plans for RMNCAH in all 6 counties*
  - *Counties' motivation to increase health budget allocations from 22% to 26% (29% to 35% for Lamu)*

Another important aspect of the strategic partnership was observed in 2020 at the height of the Covid-19 pandemic in Kenya. In a lockdown situation, pregnant women were forced to be at home without access to skilled birth attendance at the time of giving birth. In this regard, the Covid-19 situation was bound to severely increase the risk of obstructed labour, severe bleeding during labour or other critical complications that can put the women's and the child's life at risk.

During this period, the CO identified and partnered with organizations which have vast experiences in provision of services in emergencies such as Kenya Healthcare Federation (KHF), AMREF Kenya, Rescue.co (an emergency response network). Included in the partnership was a taxi ride-hailing company (Bolt) thus resulting in what came to be known as the "Wheels for Life Initiative". The initiative provided assistance to women with pregnancy-related emergencies occurring during curfew hours by providing a toll-free helpline connecting them to a doctor, and where required, free emergency transport to a hospital or maternity clinic. Additionally, there was a telemedicine component of this initiative which was valuable in educating pregnant women on their health and wellbeing at the comfort of their home, as

preliminary reports showed that many were missing their antenatal check-ups due to a fear of contracting the Covid-19 virus at health facilities or during travel using public means.

Box 2: Examples of the Wheels for Life Initiative Achievements

- *54,518 calls received through a toll-free helpline*
- *732 cabs and 593 emergency ambulances dispatched facilitating 1,325 expectant mothers to reach health facilities during lockdown*
- *An additional 3,054 mothers received assistance from doctors through the telemedicine component*

Despite the good intentions of the JP there were some notable challenges all the same but these could also be viewed as "lessons learned" which can inform further improvement of the benefits of collaborative engagement in programmes development and implementation. One of these challenges was the difference in implementation approaches adopted by the participating agencies which in itself countered the spirit of complementarity and synergy expected to form the cornerstones of successful partnerships. The JP evaluation however provided some useful recommendations which if implemented could help in harmonizing systems of participating agencies to enhance coherence in approach and implementation modalities.

Good Practice 2 - Peer Support groups:

Support formation and functioning of Peer Support groups to promote empowerment and increase access to SRHR information and services.

Peers can be a group of people who have or may have developed similar interests over time, (which could arise from age, social status or background). With interaction over time, they develop a sense of belonging to the extent that they become an important source of information, feedback, and support to each other within the group. In Kenya, examples of these may include adolescents and youth in general as well as socio-economic groups such as "Chama" ("same interest group") members.

One of the initiatives that has the potential to assist young mothers get proper information and access SRH services including family planning was the formation of the "First-time Young Mothers' Clubs" across the focus counties. This was noted to have created a forum for first time mothers to interact and share information among peers on experiences and even challenges they were facing or likely to face. Although the idea may be viewed to be still at "infancy" stage with no data yet to show the impact, it may be worth identifying and nurturing such groups to make them feel more supported during pregnancy period, birth and post-natal periods.

Organized youth groups (formed for general social or sporting purposes) could be another forum to reach adolescents and youth. In such cases, the groups can be facilitated as was the case in counties such as Migori, where the JP introduced a toll-free line where adolescents could call and be guided with relevant information such as availability of friendly services like SRHR, post-GBV, HIV testing and treatment, ANC, and family planning.

The Johari Beads initiative launched by UNFPA in partnership with Ant-FGM Board and EcoBank that promotes beadwork to give financial support to women and girls is another promising practice of peer

empowerment while providing SRH information and related services. This partnership with the 231 women cooperatives identified in 7 counties (Baringo, Kajiado, Marsabit, Narok, Samburu, Turkana, and West Pokot) was mainly for raising awareness to end FGM. However, such groups have the potential of galvanizing women support in all aspects of SRH and ending harmful practices such FGM messages and other harmful practices during their meetings and marketing of their merchandises.

Good Practice 3 - Tested innovative tools and ideas:

Utilizing tested innovative tools and ideas for timely delivery of information and services

Effective programme management is about finding the most efficient way to carry out related activities using appropriate human, material, financial and timely resources to reach target populations in different locations. For family planning services, delivery strategies need to be tailored to reach the distribution centres in a timely manner to avoid possible stock-outs when the commodities are in demand.

The adoption of the Coca-Cola Company's supply chain model through a public-private partnership (PPP) between the Kenya Medical Supplies Authority (KEMSA) and Coca-Cola Beverage Africa has been a game changer in delivery of quality family planning services. Using Coca-Cola's method of supply chain management, and with support from UNFPA, KEMSA decentralized depots in Mombasa and Kisumu and adopted depot automation, paving the way for the operationalization of regional distribution centers. A key element of this partnership was the development of a web based warehouse management system that links to KEMSA's Logistics Management Information System (LMIS) and the country's health information system (DHIS) leading to improved efficiency by enabling greater stock visibility at regional warehouses. Implementation of this automated communication system contributed to improved acknowledgement of deliveries by health facilities through the adoption of electronic proof of deliveries including development of a similar tool which is used to conduct post-distribution monitoring in selected counties.

Similarly UNFPA in partnership with HealthStrat, supported the Roll-out of Qualipharm, a mobile-based digital reporting tool that tracks consumption of family planning commodities at a county and sub-county level. Public health facilities pharmacy staff are using the gadget to electronically key in commodity numbers after taking stock at the end of each day. The app can run on any android platform device making it easily accessible for download on mobile phones. The gadget ensures uninterrupted supply of family planning commodities, ensuring that quantities ordered reflect actual needs, hence reducing wastage of resources, while averting stock outs and loss through expiries. It has an in-built data validation rule and a multilevel review and approval process which gives alerts for overstocking, wrong entries and irrational orders, minimizing errors in the process. So far, Qualipharm has been introduced in 573 healthcare facilities in six counties including Homa Bay, Migori, Kilifi, Isiolo, Marsabit and Nairobi.

It may be worthwhile exploring more of such models from other commercial enterprises and private organizations that could be embraced for efficient delivery of information and services in other aspects of SRH and GBV prevention.

Box 3: Examples from the Counties on how Qualipharm has lessened the reporting burden

- *Pascalia Ghati, is the commodity manager at Kuria West sub-county hospital in Homabay County in western Kenya. At the end of every month, reporting on the facility consumption of commodities, including family planning commodity data would prove quite challenging to her. First she would wait patiently as pharmacists and health officers from far-flung facilities within the sub-county made the long journey to manually submit paperwork to her. Then followed the process of manually entering the data into the Kenya Health Information System (KHIS). "The amount of paperwork involved was quite tedious and cumbersome," she stated.*

- *In Isiolo county, northern Kenya, Maurice Wario would have to travel 300 Kilometres every month from his work station at Dadacha Basa dispensary to reach Isiolo Referral Hospital, in order to submit commodity status reports. The journey would take him up to three days, and cost 5,000 shillings ($50) for transport and accommodation. With the manual reporting systems, delays would often prove inevitable, which would in turn interfere with stock planning and ordering of family planning commodities.*

Good Practice 4: - Engaging community and religious leaders:

Engaging community and religious leaders targeted training and supporting them to cascade national level commitments to advance gender equality and reducing harmful practices.

Cultural realities of communities in Kenya with male dominance in many spheres of decision making creates both challenges and opportunities in addressing issues related SRH and harmful practices. Dealing with, and changing, attitudes, behaviours, and mind-sets on such sensitive issues can therefore be a complex task. Thus, elders and religious leaders are key in community guidance on how to with harmful practices within their communities.

In this regard, UNFPA has provided support for orientation of religious leaders and elders on ways in which they can engage their communities in prevention and response to GBV, FGM, and Child Marriage. As a result, they created congregational action teams and disseminated prevention and response messages at the community level in the five focus Counties through inter-elders' dialogues sessions and radio talk shows. Ultimately some communities have embraced the dialogue and agreed on issuance of statements and public declarations renouncing FGM. An example of such declarations was one made by the Borana Council of Elders at the 41st Gummi Gayo (community elders' assembly) that declared FGM as an outlawed and forbidden practice within the community. The declaration also outlawed rape, child, and early marriage, and called for the equal access to education for both boys and girls.

Other ways of reaching elders have involved support provided to organizations working with the communities. UNFPA supported World Vision in piloting a community based surveillance framework, where local administrators, community leaders, anti-FGM champions and youth are trained to work within the community to detect and report suspected cases of FGM and gender based violence (GBV). In one pilot programme, the surveillance team mapped out 450 girls in the Chesong and Arror areas of Elgeyo Marakwet County. Although 74% of them had not yet been cut, the surveillance team estimate

that 64% these are at high risk of undergoing FGM. Such information is vital in guiding the follow up mechanisms deployed to ensure that the girls do not suffer FGM.

Good Practice 5 - Partnering with grassroots organizations and networks:

Partnering with grassroots organizations and networks to expand possibilities for effective and efficient reach to a wider range of key and vulnerable populations

It was observed that at the beginning of the Covid-19 crisis in March, persons with disabilities could not easily access the information the government was providing about the crisis, there was no specific strategy to ensure support for the disability community, and safety measures like social distancing and sanitizing did not reflect the realities of the lives of a majority of persons with disabilities, and women and girls with disabilities in particular. Women with disabilities had trouble accessing food assistance programmes, which were in high demand and often required hours of queuing to get assistance, limiting their ability to independently meet their basic needs. Additionally, there was an increase in sexual violence, leading girls with disabilities to experience unwanted pregnancies and leading their families to consider sterilizing them as a misguided measure of "protection."

Therefore, UNFPA partnership with an organization called This-Ability - a women-led organization focused on women and girls with disabilities working on advocacy, rights (economic rights and SRHR), social norms, and sustainability – came in handy in addressing the challenges brought about by the Covid-19 pandemic. The Organization has established a system with two focal points in each of the 8 Counties who help identify those in need of required support. With this partnership, new technologies were introduced to empower women with disabilities on their sexual and reproductive rights. These included PAZA podcast, an eLearning platform, a Toll-free number, and a Bulk SMS system. About 2,000 women with disabilities registered in the This Ability database were reached with user-friendly integrated SRH, FP and GBV information and services.

Based on the added partnership with Global Fund for Women, and African Women Development Fund, the Organization provided in-kind support which included cash transfers of $30 per month as well as dignity kits provided by UNFPA. By the end of 2020, this in-kind support had reached approximately 300 women with disabilities.

UNFPA similarly partnered with the Feminists for Peace, Rights and Justice Centre (FPRJC) based at the country's largest informal settlement (Kibera) to provide technical and financial support in the provision of GBV response services. The Centre's current estimated outreach is nearly 600 women benefitting from various integrated services, including monthly support group meetings for survivors of gender based violence and training on income generating activities. Other support activities include legal aid and sheltering women and girls who have suffered gender-based violence, offering short-term emergency accommodation before referring the survivors to larger shelters for long term help. Community health volunteers from FPRJC similarly conduct regular door to door visits distributing all range of contraceptives to vulnerable women living in Kibera and give health talks to encourage victims of sexual and gender based violence to seek medical attention if required.

The import of this partnership is that the organization's leadership as well as the community health volunteers come from within the informal settlement and therefore can easily relate to the lives and challenges of their target audience hence ease of acceptability of their roles.

Another significant partnership was the support provided during the launch Women Chapter of the Boda Boda Safety Association of Kenya, an association of motorcycle riders providing transport services to individuals and luggage in different parts of the country. Given that this has all along been a male dominated venture, the entry of women with required support can facilitate the sharing of information on ending teenage pregnancy and harmful cultural practices such as GBV, FGM and child marriages in the country. Therefore, targeted follow programmes to the group would be desirable sustain the momentum created during the launch.

Good Practice 6 - Flexibility in programming:

Flexibility in programming and use of innovative channels for service delivery continuity and expansion even during a crisis or emergency/pandemic situation.

As the Covid-19 situation in Kenya escalated, it became apparent that most of the health sector human resources will be deployed to manage the situation. Under the circumstances and in realization of the possibility of overlooking the SRH including maternal health element, the Country Office provided financial and technical support to the Ministry of Health for the development and rollout of the National Covid-19 Reproductive, Maternal and Neonatal Health (RMNH) guidelines, and the country's home based care programme.

This was critical in ensuring continued focus on reproductive, maternal, and neonatal health services even as health facilities were stretched in dealing with a surge in Covid-19 patients. Following the launch of the guidelines, 1,588 health care workers were sensitized on COVID-19 and continuity of RMNCAH services amid the pandemic. UNFPA further provided infection prevention and control supplies like hand sanitizers, facemasks and sodium hypochlorite at facility and community level for the health workers. Thus despite the challenges posed by the pandemic, it was ensured that 92 % of the county referral facilities maintained the pre-Covid level of institutional deliveries.

UNFPA Supported Health Assistance Kenya (HAK) during Covid-19 lockdown to upgrade their Toll-free helpline's data collection and management system. This support and provision of technical support for data analysis was very instrumental in tracking the prevalence of GBV during the pandemic. The data generated also provided evidence based insights that informed GBV response and programming by the Government and other stakeholders. From 100 calls received in January 2020, the number had risen to 785 by June 2020, an increase of nearly 600% while between March and December 2020 about 6, 297calls were made to the helpline by GBV survivors and at risk women and girls. The initiative greatly enabled responders to offer psychosocial first aid services to survivors, before linking them to additional services such as nearby facilities that provide medical treatment, local police, as well as legal aid and rescue shelters.

Good Practice 7 - Strengthening accountability and response mechanisms:

Strengthening accountability and response mechanisms for a shared responsibility towards ending harmful practices including FGM, GBV, and Child Marriage

UNFPA supported a number of policy and legal frameworks to prevent and respond to GBV, FGM and other harmful practices which in effect enforces the idea of shared responsibilities among the stakeholders in the fight against these vices. At the National level, with financial and technical support from UNFPA, the costed Presidential acceleration action plan to end FGM was developed and a monitoring and evaluation framework to support the implementation of the same. Twenty-one county draft policies and twenty-three draft county action plans on ending FGM were developed at the county level.

The Intergovernmental consultative framework on gender signed in 2019 has also been a binding factor among the stakeholders implementing gender programmes between the National and County Governments and has also increased funding for gender programmes. To buttress these policy documents, UNFPA supported the training and establishment/restructuring of the County GBV working Groups play roles in facilitating a comprehensive and coordinated approach to GBV and FGM, including prevention, care, and support and coordinating multi-sectoral approaches for the effective prevention of and response to GBV among government, CSO, FBO, academics and other stakeholders.

Other supportive actions have included: the development of a training curriculum of judicial officers on prevention and response to GBV and FGM as well as an e-course for the National Police service which will be used to train police officers on response procedures to GBV and FGM cases; establishment of community-based teacher lobby groups and a social media platform to identify FGM, child marriage and teenage pregnancy cases; and support to the Ministry of Education in finalizing the National guidelines for school re-entry in early learning and basic education. The guidelines provide a framework to enhance re-entry for learners who drop out of school due to several reasons including teenage pregnancies and harmful traditional practices such as child marriages and FGM.

All these are due to the realization that every stakeholder has a role to play not only in the prevention of these practices but also be in a position to manage the consequences where the acts have taken place.

Good Practice 8 - Active engagement of young people and youth networks:

Active engagement of young people and youth networks in advocacy, programming and demand creation for adolescent and youth SRH services.

The CO supports initiatives to engage young people in advocacy, demand creation, and in raising SRH awareness of adolescents and youth through the Youth Advisory Panel, youth networks, peer educators, training and online digital platforms. These approaches help build confidence and skills among adolescents and youth and are more likely to encourage behaviour change. Use of digital and online platforms has potential to increase access by adolescents and youth to SRH information and services due to the fact that young people are now spending increasing time on digital and online platforms.

Several good initiatives of making use of technology/social media have been supported by the Country Office to engage young people to contribute on how to address their needs. The CO employed multiple

platforms to reach a number of 337,462 adolescents and youth with critical lifesaving information on SRHR. About 207,250 were reached by way of short films disseminated through various social media platforms (Facebook, Instagram, Twitter and YouTube).

Similarly, the CO partnered with a teenage girl advocate (aged 15 years) to highlight the plight of teenage mothers with the making of a documentary feature on teenage pregnancy in Nairobi's Kibera Informal Settlement (The Teen Moms of Kibera). The documentary explored the social challenges faced by adolescent girls in the slum, launching a conversation on how they correlate to the existing high teenage pregnancy rates. It was aired on a major national media outlet - Citizen TV - reaching an audience of over four million.

The other event was the live Facebook virtual sessions with young people across the country organized by the UNFPA Youth Advisory Panel on topical SRHR issues such as teenage pregnancy, GBV and FGM that were emerging during the COVID-19 pandemic period. An estimated 71,400 young people were engaged in through this forum.

Good Practice 9 - Sustained advocacy at all levels:

Sustained advocacy at all levels, backed by strategic information for supportive evidence.

UNFPA coordinated high-level dialogues on increased domestic financing of FP commodities with the Parliamentarians and senior Government Officers including Cabinet Secretaries, Principal Secretaries from key institutions; as well as County Chief Executives. UNFPA, in close collaboration with the NCPD and other stakeholders, advocated for prioritization of FP as a key development agenda and a key driver in achieving the 'Big Four' Government's Agenda. At the same time, UNFPA also palyed a major role in coordinating Donors and Development Partners' commodity security dialogue sessions.

To complement advocacy on increased domestic financing of FP, UNFPA provided financial and technical support to undertake a rapid analysis of the free maternity programme (the Linda Mama programme) through the National Hospital Insurance Fund (NHIF). The assessment findings were instrumental in advocating for increased domestic financing of family planning by identifying the available resources for sustainable domestic financing.

A major achievement of these efforts was the Government commitment to make FP a strategic commodity and the pledge to return procurement of contraceptives to central level. Family planning has also been included in the "Strategic Commodity" category a necessary component of UHC and following drafting of an MOU outlining the long-term cost-share financing of FP Commodities with key FP Donors and Development Partners (DFID, BMGF, USAID, Clinton Health Access Initiative (CHAI), the Government gradually shifted to 100% domestic financing of contraceptives in order to increase GOK accountability on the fulfillment of its commitment.

Good Practice 10 - Creative demand stimulation:

Creative demand stimulation where socio-cultural barriers are rampant for increased uptake of key RMNCAH, HIV and GBV services

Community-based demand side interventions are very critical for universal access to health services especially maternal and adolescent health. This can be realized mostly if women and young people are cared for in their own communities and are empowered to take decisions about their own health in a supportive environment. It is a well-known fact that in Kenya, many communities are still laden with socio-cultural norms and practices which are still having an impact on reproductive, economic and social behaviours including gender roles. One of these is the reliance on traditional birth attendants (TBAs) and male dominance are quite rampant especially in many of the counties that account for high rates of indicators such as maternal mortality GBV incidences. Therefore, innovative interventions introduced during the implementation of the RMNCAH Programme saw significant improvement in the demand for RMNCAH/HIV/ GBV Services. These included selection and training of TBAs to be collaborators in referral of pregnant mothers, purchase and distribution of "Mama Kits", and as well as engagement of men and boys using their existing social forums.

As noted in the final evaluation of the Programme, the introduction of the "Mama Kits" was some kind of a "game changer" in the six focus Counties significantly contributing in attracting mothers to health facilities for the 4 ANC visits and also at the time of delivery. It was noted that in some cases, there were more mothers visiting health facilities for delivery when these kits were available than when there was a stock-out of the kits. On the part of the selected TBAs, the training they were offered on various RMNCAH areas including danger signs in pregnancy in addition to transport re-imbursement of Ksh 500 for every referral of a mother in labour turned them into quite active collaborators. The re-oriented TBAs were mainstreamed into the health system thus referring clients seeking their services in their homes to health facilities where they got safe and skilled delivery services.

Male mobilization through "He for She" - Male champions campaigns was one of the innovative approaches to reach men and boys. Through male champions, the program conducted community engagements and mobilized men towards changing attitudes and practices to become champions against GBV and also promoting women's use of SRH services. Each male champion is assigned to engage 20-25 men in community dialogue. In the Coastal Region, it is common to get men or boys gathered in the evening over a cup of coffee discussing general social, political and sports issues. This was well utilized for example in Lamu County where the men and boys engaged designed a community outreach activity targeting men in social evenings - The "Kahawa Evening Dialogues" - where they were able to prepare coffee, and snacks bringing together men and boys to discuss RMNCAH and ending GBV. These community spaces have been found to sustain engagement of men and boys and the community at very minimal cost.

These initiatives coupled with other factors at the facility (such as quality of care) and community mobilization efforts by CHVs and TBAs have to a larger extent contributed to improvement in indicators especially on attendance of 4 ANC visits and proportion of skilled birth attendance across target counties. The Evaluation Report reveals that proportion of pregnant women attending at least 4 ANCs and use of skilled birth attendants increased significantly in Counties such as Mandera (12% to 24% and 29% to 69% respectively); Marsabit (37% to 46% and 46% to 76% respectively) and Migori (36% to 68% and 60% to 85%respectively) between 2016 and July 2020. Even in the other Counties, data especially on skilled birth attendance is quite encouraging for example in Lamu (57% to 89%) and Isiolo (68% to 93%) during the same period.

A major challenge for most of these initiative is the strategy for sustainability. It is however gratifying to note as indicated in the evaluation report that some of the Counties have incorporated in their annual work plans financing of these demand enticing initiatives such as Mama Kits to sustain demand for RMNCAH services especially skilled birth attendance. What is required then is for the respective programme implementers to refocus the support to ensure that the ideas become appreciated in the counties and then continue with their advocacy efforts with the County Governments to ensure that all these components becomes part of the referral strategy in their plans and provision of services.

Conclusion and Recommendations

A number of challenges have been noted in all the reports reviewed which could have a bearing in a way on some or all of the good practices that have been highlighted. These range from different approaches used by the H6 Joint Programme participating agencies to implement the interventions thus impacting on the complementarity and synergy intended for the programme; high turnover of trained health care workers some counties for various reasons; leadership transitions and staff exits; and low utilization of some intervention such as maternity shelters due to counties due to socio-cultural barriers and operational costs that affected its utilization. The presence of TBAs who are still active across the six counties coupled with the real risk of engaged TBAs reverting back to active delivery since a majority of them do not have alternative income generating activities was also sites as a challenge that could potentially negate the gains made. Another weak link is that of volunteers who are engaged by a number of implementing partners either purely on voluntary basis or with token incentives.

However, in addition to the clear recommendations provided by the evaluators, and as indicated somewhere in this report, there is need to view these challenges as "lessons learned" in order to come up with robust ways of addressing them in subsequent programmes so as not to lose the gains made in previous programmes' investments.

For example, in the case of TBAs and those offering services on voluntary basis, efforts need to be made to categorize them into suitable "peer" groups who can be assisted to come up with "joint" income generating activities they can engage in while providing services, say as part of the referral system, instead of depending on "stipends" per the activity done. In addition to the "seed" funds which may be availed from the implemented programmes, efforts should be made to advocate for county and constituency development plans to incorporate and budget for such groups in same way there had been the intentions of the likes of the "youth fund".

On the programmes side, it will be noted that some of the good or promising practices highlighted may be lacking strong evaluative evidence to strongly support them. This can be addressed by ensuring sufficient data is collected for each of the initiatives put in place to support programme implementation. For example the component of male "champions" (as is the case of "Kahawa (coffee) evening dialogues") need to be followed up by finding ways of documenting the level or even number of referrals or persons whose behaviour change each of the "champions" was able to influence the same way was done for the incorporated TBAs. The same case with the peer groups cited in the good practices including the youth, first-time mothers and empowerment groups like the Johari Beads initiative group.

With strong supportive data documented, the programmes have the potential to generate more good practices or refine more the once highlighted. Hence these factors whether institutional or programmatic, present an opportunity for programme implementers and other duty bearers including policy makers to reflect and come up with strategies to address them, and further optimize on those that have facilitated efforts to achieve desired results.

Annexes

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