FINAL REPORT

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END TERM EVALUATION OF

THE UN H6 JOINT PROGRAMME ON REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH (RMNCAH)

2015-2020

unicef unite for children

UN WOMEN United Nations Entity for Gender Equality and the Empowerment of Women

UNFPA

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World Health Organization

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Map of Kenya showing UN H6 RMNCAH implementation counties

UN H6 Joint programme implementing counties

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ASD	Age of Sexual Debut
AWP	Annual Work Plan
CO	Country Office
CSO	Civil Society Organizations
EM	Evaluation Manager
ERG	Evaluation Reference Group
ESARO	East and Southern Africa Regional Office
ETE	End-Term Evaluation
FCDO	Foreign, Commonwealth & Development Office
FGD	Focus Group Discussion
FP	Family Planning
GBV	Gender Based Violence
GDP	Gross Domestic Product
GoK	Government of Kenya
H6	Partnership among UNAIDS, UNICEF, UNFPA, UN Women, WHO, and World Bank
HIV	Human Immunodeficiency Virus
JP	Joint Programme
IP	Implementing Partner
KASF	Kenya AIDS Strategic Framework
KDHS	Kenya Demographic Health Survey
KI	Key Informant
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MTP	Medium Term Plan
PMTCT	Prevention of Mother to Child HIV Transmission
PRSP	Poverty Reduction Strategy Papers
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
TOR	Terms of Reference
TWG	Technical Working Group
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
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Purpose of End Term Evaluation of the UN H6 Joint Programme on RMNCAH

The purpose of the End-Term Evaluation of the Joint Programme on Reproductive, Maternal, Newborn, Child, and Adolescent Health, HIV and GBV was to conduct an in-depth analysis to assess progress made in achieving planned results as contained in program results framework. Thee evaluation report will be used by UNH6 agencies to account to donors and other involved stakeholders including the Government of Kenya, Development Partners among others.

Evaluation objectives and scope

The evaluation aimed to: (i) Assess the relevance and contribution of the RMNCAH programme to the national and county plans (ii) Assess the extent to which the programme implementation successfully achieved the outcomes; (iii) Assess the extent to which the programme objectives have been achieved, with the appropriate amount of resources; (iv) Assess the continuation of benefits after its termination, linked, in particular, to their continued resilience to risks; (v) Assess the coordination of the Programme implementation among UN H6 partners and the programme counties; (vi) Generate a set of clear forward looking and actionable recommendations logically linked to the findings and conclusions.

The evaluation covered interventions carried out during the programme period (2015-2020) in all three programme objectives; Improved access to, and quality of, integrated RMNCAH, HIV, and GBV services; Increased demand for quality RMNCAH, HIV, and GBV services; Strengthened institutional capacity at county and national levels for planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services. Geographically, the evaluation covered the counties of Migori, Isiolo, Wajir, Marsabit, Lamu and Mandera where the programme was implemented.

Methodology

The ETE adopted an inclusive and participatory approach, involving a broad range of partners and stakeholders at both national and county levels. A mixed methods approach, combining qualitative and quantitative data collection and analysis techniques was used to obtain data and generate information to evaluate the effectiveness of the project interventions. The ETE assessed the UNH6 JP on RMNCAH in relation to relevance, effectiveness, efficiency, sustainability, and coordination and partnership. The Evaluation Questions below guided the process and explored assumptions. Qualitative data was collected through Focus Group Discussions and Key Informant Interviews with representatives from national and county governments, civil society organizations, UN H6 agencies, USAID, FCDO (Foreign, Commonwealth & Development Office) and programme beneficiaries. Site visits and observation were conducted in eight facilities in Isiolo and Migori counties. Contribution analysis was used as core analytical approach based on the intervention logic illustrating the causal links and causal assumptions and was used to identify how documented inputs and activities contributed to outputs and outcomes. Trend analysis was undertaken to explore change in programme indicators over time between 2015 and 2020. Thematic content analysis primarily relating to beneficiary FGDs and KIIs was conducted.

Main conclusions

The strategic conclusions of the evaluation are that the UNH6 Joint Programme on RMNCAH, HIV and GBV was relevant and aligned to international development goals (SDGs 3 and SDG 5), UNDAF outcomes on Human Capacity Development, county and country priorities as contained in Kenya's vision 2030, Medium Term Plans, strategic plans, and the specific needs of target direct and indirect beneficiaries. As a UNDAF Flagship initiative, the programme has also demonstrated that the UNH6 partnership can Deliver as One (DaO) with adequate planning and consultations. However, due to differences in internal processes among the agencies, the programme was administratively complex and UN agencies need to explore more streamlined approaches for enhanced efficiencies when implementing similar programmes.

Through sustained advocacy efforts, the programme greatly succeeded in creating prominence for RMNCAH/HIV/GBV/SRHR services to end preventable maternal, child and neonatal deaths in high burden counties including the six target counties.

The programme contributed significantly towards improving access to, and quality of, integrated RMNCAH, HIV, and GBV services in the six counties between 2015 and 2020 through provision of equipment, capacity building, and community based advocacy and strengthening referral system. Proportion of women attending four ANC visits in the 6 programme counties increased from an average of 43 percent to 57 percent while skilled delivery increased from 50% to 65%; Proportion of L2 to L4 health facilities providing BEmONC services increased from 53% to 65% while number of women utilising modern contraceptives, survivors of GBV who attend health facilities and women who received HIV testing and counselling increased gradually from 2016 to 2020. Introduction of KMC and ICCM interventions across the counties significantly improved health of neonates and children. Adolescent Health was improved through several interventions such as first-time Young Mothers Club, Toll free line number and engagement forums where adolescents freely engaged and shared SRHR information among peers and health care workers.

Proportion of women attending four ANC visits increased from an average of **43%** to **57%** while skilled delivery increased from **50%** to **65%**

The evaluation also established that the programme contributed significantly in strengthening institutional capacity at the six counties towards planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services as well as enhanced accountability for RMNCAH through MPDSR, RMNCH Score cards and institutionalization of quality improvement using KQMH. However, the COVID-19 pandemic has significantly affected access and utilisation of essential health services including RMNCAH, HIV and GBV since March 2020 when the first case was identified in Kenya till the time of this evaluation. As a result, reprogramming was undertaken, and this might affect the achievement of some targets.

The major strength of the programme was the health systems approach used to implement interventions in the targeted counties, and was overlay efficient in utilising the human, financial and technical resources to pursue the three programme outcomes. Programmatically, the Joint Programmes demonstrated flexibility to adjust and respond to changing needs and priorities in the targeted counties and contributed to resource mobilization for RMNCAH in Kenya through stimulating increased domestic resource allocations by the six counties which gradually increased their allocations to health from an average of 22 percent to 26 percent between 2016 and 2020 as well as forging private sector partnerships that availed additional resources invested in critical programme areas. Through advocacy, the programme contributed and influenced various policies developed at National level and at county level such as the GBV policy in Migori county, ASRH action plans and Costed Implementation Plans for RMNCAH in all 6 counties. It is however, notable that different approaches used by the H6 Joint Programme participating agencies to implement the interventions threatened the complementarity and synergy of interventions.

Some of the key challenges faced by the programme included high turnover of trained health care workers aggravated by the insecurity affecting mainly Mandera, Wajir and Lamu Counties; leadership transitions and staff exits; and low utilisation of some intervention such as maternity shelters especially in Isiolo and Marsabit 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 noting that a majority of them do not have alternative income generating activities is also a challenge that potentially negate the gains made.

Programmatically, the lack of dedicated programme M& E staff and the weak sharing of data/information and lessons learnt at the national level during implementation phase were some of the challenges.

Most of programme interventions such as capacity building of the existing health systems and structures in the six counties through training of health care workers, county officials and anti-GBV champions, embedded technical assistance, infrastructural improvement and equipping of health facilities, establishment of referral systems and community health units are inherently sustainable by the counties., Sustainability of the of improvements in service quality and availability in RMNCAH, HIV and GBV services is however, still at risk as a result of the programme having weak or undeveloped exit plans and strategies. Some counties have incorporated some demand side financing initiative such as Mama kits among others in their annual work plans to sustain demand for RMNCAH services especially skilled birth attendance.

Main recommendations

At strategic level,

MOH, counties and UN H6 Partners need to strengthen their strategic partnerships and mobilize more resources to optimize contribution to RMNCAH/HIV/GBV and sustain gains in high burden counties significantly contributing to high maternal and neonatal mortality burden.

For enhanced efficiency of JP implementation, UN H6 Partners should harmonize approaches, work more closely, and explore alternative funds flow modalities to enhance coherence and efficiencies.

Future RMNCAH programmesshould incorporate advocacy and stakeholder engagement at design stage and sustain with adequate funding throughout programme cycle

At programme level,

Counties should scale up innovative and sustainable approaches on capacity building of HCWs and leadership to mitigate high turnovers of trained health care workers and leadership transitions that pose a challenge to sustaining program gains made so far.

Counties should consider supporting TBAs to have alternative income generating activities as a sustainability measure to deter them from reverting into active TBAs whenever incentives are not available.

The UNH6 partners and counties should strengthen the learning and knowledge management strategy of joint programmes, including the generation and routine dissemination of evidence-based documentation especially achievements and lessons learned throughout programme cycle

When implementing Joint Programmes, UN H6 agencies should use a harmonised approach when implementing joint programmes to avoid delays that threaten the complementarity and the synergy of interventions.

MOH, County Governments and H6 partners should harness multi-stakeholder-partnerships including Private-Public Partnerships to mobilise more resources to address critical gaps in RMNCAH while advocating for increased domestic resources to sustain gains of RMNCAH interventions based on a clear exit strategy.

UN H6 Partners and counties should strengthen coordination in implementation among agencies beyond joint planning and reviews of programmes. Approaches to strengthen complementarity at activity level should be promoted and H6 partners should approach both the county and the national level jointly during implementation ensuring adherence to joint implementation frameworks while building complementarity and synergy of programme interventions.

Lessons learnt

- Building capacity of health workers with varied technical expertise and sustaining them within counties and building capacities of communities and having less reliance on the national level is very essential and ensures continued provision of services even in pandemics like COVID-19.
- Flexibility in the design of a program is critical when implementing programmes in dynamic and varied county contexts in addition to addressing emerging issues and needs.
- Partnerships with key stakeholders (such as government, UN agencies, development partners, the private sector, CSOs and community) helps to leverage on existing financial resources and technical expertise of various institutions to successfully mobilise resources, successfully implement and influence government.
- Conducting a baseline assessment to identify needs and disparities in maternal, neonatal and child mortality burden before designing of any programme is very critical. This provides essential information to guide prioritization of fewer counties but with the highest contribution to high maternal mortality.
- Integration is key to delivery of successful RMNCAH/HIV and GBV program and any other program that utilizes that approach, especially with limited resources a lot can be achieved.
- Demand side interventions such as the transport vouchers, Mama kits, TBA vouchers and creative male involvement strategies such as “Kahawa sessions” are effective in demand stimulation where socio-cultural barriers are rampant and contribute to increased uptake of key RMNCAH, HIV and GBV services.

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Chapter
01

Introduction

1.1 Purpose and objectives of End Term Evaluation of the UN H6 Joint Programme on RMNCAH

The purpose of the End-Term Evaluation (ETE) of the Joint Programme (JP) on Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) was to conduct an in-depth analysis in order to assess progress made in achieving planned results, including efficiency in the utilization of resources., and produce a report which will also be used by UNH6 agencies to account to donors and other involved stakeholders including the Government of Kenya (GOK), Development Partners among others.

The overall objective of the ETE was to provide an independent assessment of the progress of the JP on RMNCAH towards achieving the expected outcomes as set forth in the results framework of the programme as well as make recommendations that will guide designing of future support to strengthening counties' capacity on RMNCAH.

The specific objectives[1] of the ETE of the JP on RMNCAH were to:

- Assess the relevance and contribution of the RMNCAH programme to the national and county plans e.g. Kenya Health Sector Strategic Plan (2013-2017), County Health Strategic Plans among others.
- Assess the extent to which the programme implementation successfully achieved the stated objectives, including establishing how Implementation framework enabled or hindered achievements of the results chain i.e. what worked well and what did not work well.
- Assess the extent to which the programme objectives have been achieved, with the appropriate amount of resources (funds, expertise, time, administrative costs etc.).
- Assess the continuation of benefits after its termination, linked to their continued resilience to risks.

1 Terms of Reference for the Evaluation of the Un H6 Joint Programme Reproductive, Maternal, Newborn, Child And Adolescent Health (RMNCAH) 2015-2020

- Assess the coordination of the Programme implementation among UN H6 partners and the programme counties.
- Generate a set of clear forward looking and actionable recommendations logically linked to the findings and conclusions.

1.2 Scope of the Evaluation

The ETE of the JP on RMNCAH covered interventions carried out during the programme period (2015-2020) in technical and management aspects as well as cross-cutting aspects such coordination, monitoring and evaluation and partnerships. The evaluation assessed all three programme objectives; Improved access to, and quality of, integrated RMNCAH, HIV, and GBV services; Increased demand for quality RMNCAH, HIV, and GBV services; Strengthened institutional capacity at county and national levels for planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services. The ETE also assessed the impact of the JP on the county capacity to sustain the interventions and results gained.

Geographically, the ETE covered the counties of Migori, Isiolo, Wajir, Marsabit, Lamu and Mandera counties where the programme was implemented. The evaluation took place over the period 15th July 2020 to 25th September 2020 and covered the planned and implemented interventions of the joint UN H6 Programme on RMNCAH from 2015 to 2020.

1.3 Methodology and process

1.3.1 Methodological Approach

The ETE adopted an inclusive and participatory approach, involving a broad range of partners and stakeholders at both national and county levels. A mixed method approach i.e. combining qualitative and quantitative data collection and analysis techniques was used with emphasis placed on participatory data collection approaches to obtain data and generate information to evaluate the effectiveness of the project interventions.

Drawing on the full list of evaluation criteria used by United Nations Evaluation Group (UNEG)/Organization for Economic Cooperation and Development (OECD), and as stipulated in the UNFPA Evaluation Handbook and ToR (annex I), the ETE assessed the UNH6 JP on RMNCAH in relation to relevance, effectiveness, efficiency, sustainability, and coordination. The cross-cutting themes of coordination, monitoring and evaluation and partnerships were also covered by the evaluation. The Evaluation Questions (EQ) guided the process and were explored in relation to assumptions as highlighted in the Evaluation Matrix (Annex IV).

EQ1: Relevance

1. To what extent is the RMNCAH programme adapted to national and county needs and policies?
2. To what extent did the UN RMNCAH JP address needs and priorities of beneficiaries including women of reproductive age, girls, adolescents, young people, vulnerable people, and indirectly healthcare providers? How valuable were the results to beneficiaries?
3. Has the H6 RMNCAH programme been able to adequately respond to changes in needs and priorities, and to specific requests from the national and county stakeholders?

EQ2: Effectiveness and Strategic Alignment

1. To what extent did the interventions supported by the programme in all areas contribute to the achievement of planned results (outputs and objectives as stipulated in the results framework)?
2. To what extent has RMNCAH programme supported interventions contributed to the capacity development and service delivery in the 6 Counties and addressed the most pertinent needs?
3. To what extent are the H6 partners coordinated for effective delivery of the RMNCAH programme
4. To what extent are the H6 partners strategically aligned with other UN Agencies for effective UN Coherence

EQ3: Efficiency

1. To what extent have the H6 Partners made good use of its human, financial and technical resources to pursue the achievement of the objectives defined in the RMNCAH programme Document?
2. Were the available resources adequate to meet RMNCAH JP Needs? Was the approach used to support the county efficient? Are there more efficient ways and means of delivering more and better results (outputs and outcomes) with the available inputs? Could a different approach have produced better results?
3. Did project activities overlap and duplicate other similar interventions (funded/supported by other donors?)

EQ4: Sustainability

1. To what extent have the partnerships established by RMNCAH programme promoted the national ownership of supported interventions, programmes and policies?
2. To what extent are the benefits of the programme likely to be sustained by the county government after the completion of this partnership i.e. beyond 2020?

EQ5: Coordination and Partnership

1. What are the main comparative strengths of H6 Partners in Kenya and how are these perceived by the national, County and international stakeholders?
2. To what extent are the H6 Partners coordinated in implementation of the RMNCAH programme, including adherence to the Implementation Framework?
3. To what extent are the H6 partners coordinated with other UN agencies to Deliver as One, particularly in the areas of potential overlap?

1.3.2 Methods for Data Collection and Analysis

The ETE adopted an inclusive and participatory approach, involving a broad range of partners and stakeholders at both national and county levels. The stakeholders included representatives from the government, civil society organizations, UNH6, USAID, FCDO (Foreign, Commonwealth & Development Office) and other bilateral donors and most importantly, the beneficiaries (direct and indirect) of the programme.

The evaluation adopted several data collection methods and systematically triangulated data from different sources to ensure a robust analysis and understanding of the programme logic and its theory of change. Both qualitative and quantitative data collection techniques were used. Qualitative data was collected through Structured Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs) with representatives from government, civil society organizations, UNFPA, WHO, UNICEF, UNAIDS, UN Women, World Bank, USAID, FCDO and other bilateral donors and programme beneficiaries (Annex II). Quantitative data was also collected through review of secondary sources of information.

Document Review was undertaken to develop a comprehensive understanding of the JP RMNCAH programme interventions and involved an assessment of existing peer-reviewed and grey literature as well relevant project documentation as presented in annex III. **KIIs** were held with key stakeholders using semi-structured guides on the evaluation questions. Besides UNH6 and implementing county governments, stakeholders included policy makers and RMNCAH programme leads in government and donors. Most KIs were conducted virtually via online platforms (Zoom, Google meet or Skype) and over the phone at national and county levels as needed. **FGDs** were also held selected primary beneficiaries during field visits in Migori and Isiolo counties and captured qualitative data regarding beneficiary experience of programme activities supported by JP on RMNCAH. **Site visits and observation were conducted** Isiolo and Migori counties and contributed to understanding the overall context, facilities and resources for project activities as well as provided a snapshot of beneficiaries and of staff/beneficiary interactions, allowing assessment of factors that could not arise during interviews or be apparent in reports.

Methodologically, data collection tools were applied as indicated in the table below:

Table 1.1: Data source and Tools

Data source	Data collection tool
UN H6, donors, government, implementing partners	Semi-structured interview Key informant Guides
Beneficiaries, some IP staff (beneficiary facilities, TBAs)	Focus group discussion guide
Field visits to programme sites	Observation checklist, KI interviews beneficiary FGDs

The evaluation utilized contribution analysis as its core analytical approach based on the intervention logic illustrating the causal links and causal assumptions that inform the programme chain of effects. Contribution analysis identified how far documented inputs and activities contributed to outputs and outcomes. An exploration of the theory of change in the results chain logic for relevance and sufficiency of the inputs and activities to achieve outputs and contribute to the three outcomes was also done. Additionally, trend analysis was undertaken to explore change in programme quantitative results over time between 2015 and 2020. Thematic content analysis primarily relating to beneficiary FGDs and KIIs was conducted. Findings were systematically triangulated from the various sources to ensure robustness and closely referenced. This led to conclusions and recommendations concerning the appropriateness of indicators, outputs and targets, or regarding other factors that made it challenging to achieve effective monitoring. In the event of conflicting data, further interviews and/or document reviews were undertaken where possible.

1.3.3 Limitations of the evaluation

Some of the limitations and risks encountered during the ETE and the mitigation responses are highlighted in table 1.2 below

Table 1.2: Limitation and mitigation responses during the ETE

Limitations and Risks	Mitigation Responses
Travel restrictions related to COVID-19 pandemic	Digital platforms such as Google meet, Zoom, skype, phone/ conference calls will be utilised to collect data.
Limited availability of county staff due to competing tasks as a result of COVID-19 emergency response	Discussions will be held particularly with county staff on the data collection schedule and agreed changes to schedule done before design report is finalised and submitted.
Inability to collect some data especially non-verbal cues due to COVID-19 containment measures such as ban on physical gatherings, social distancing etc	Where possible, video links will be used during KI interviews and FGDs

Despite the limitations noted, the evaluation team is confident that they were sufficiently resolved. While these risks and limitations were real, they do not seriously weaken the overall validity of the evaluation design or the suitability of the methods chosen for data collection and analysis.

1.3.4 End-Term Evaluation process

The ETE followed the five phases of the evaluation process as outlined in the UNFPA Evaluation Handbook[2]. The five phases were:

1. **Phase 1 (preparatory phase):** This phase was led by the M&E specialist and programme coordinator before recruitment of consultants. Largely involved drafting of Terms of Reference with input from other UNH6 partners, approval of ToR by the Evaluation Office, recruitment of consultants, Compilation of initial documentation list, and reconstitution of ERG for the ETE.

2. **Phase 2 (Design phase):** This phase involved orientation of the team and extensive desk review, introduction of evaluation team to key stakeholders (UN H6, county implementing partners, and ERG), stakeholder mapping and stakeholder selection for KIIs and FGDs and developing the design report.

3. **Phase 3 (Field Phase):** The third phase involved actual field and virtual data collection and analysis. Testing and refinement of the evaluation matrix and tools was conducted during this phase.

4. **Phase 4 (Reporting phase):** This constituted synthesis and reporting phase of data collation, triangulation and analysis, developing the draft report and presenting it for review by UN H6 and ERG. The consultants then refined the report based on review comments.

5. **Phase 5 (Facilitation of use and dissemination phase):** During this phase the consultants made presentation of the report to ERG. Any additional final inputs were incorporated, and the report finalized.

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Chapter
02

Country Context

2.1 Country context overview

Geographically, Kenya lies across the equator on the East Coast of Africa[3]. The country landmass size is approximately area of 225, 000 sq. miles (582, 646 sq. km) with over 80 percent of the land being arid and semi-arid while only 20 percent of the land is arable[4]. Administratively, the country has 47 devolved county governments with some executive authority invested in government and responsibility of some key services including health, agricultures within their geographical area. However, policy formulation including RMNCAH policies and frameworks is handled by the national government Ministry of Health.

Kenya has an approximate population of 47,564,296 with an intercensal growth rate of 2.2% between 2009 and 2019[5]. However, some development partners estimate the current population to be about 53 million[6].

It is estimated that 85.52 percent of Kenyans are predominantly Christians while Islam is the second largest religion in Kenya, practiced by 10.91 percent of Kenyans.

Kenya has made significant political, structural, and economic reforms that have largely driven sustained economic growth, social development, and political transformation. Kenya's economy is the most developed and diversified in East Africa with main economic drivers being agriculture, service delivery and industry contributing to 34 percent, 45 percent, and 17 percent of GDP respectively[7]. The 2019 Economic Survey Report of the Kenya National Bureau of Statistics launched in 2020 reported a 5.4 per cent GDP growth rate in 2019 compared to a growth of 6.3 per cent in 2018[8].

3 General Information about Kenya/ https://www.un.int/kenya/kenya/general-information-about-kenya

4 USAID: Agriculture and Food Security/ https://www.usaid.gov/documents/1860/agriculture-and-food-security

5 2019 Kenya Population and Housing Census Results/ https://www.knbs.or.ke/?p=5621

6 World Bank/https://data.worldbank.org/indicator/SP.POP.TOTL?locations=KE

7 https://thecommonwealth.org/our-member-countries/kenya/economy

8 Kenya National Bureau of Statistics, Economic Survey 2020

The national GDP per capita for Kenya has also grown, rising from USD775.00 in 2009 to USD 1,816.5 in 2019. However, the negative impact of the COVID-19 pandemic on the economy is projected to reduce the GDP per capita to USD 1090.00 by the end of 2020. The improving economic data saw Kenya declared a lower middle-income country in 2014.

2.2 RMNCAH Situation

Kenya has made remarkable progress in improving RMNCAH outcomes during the last decade. Improving access and coverage for RMNCAH services is a priority for the Government of Kenya. The table 1 below summarises performance of the six counties that were targeted by the UNH6 JP on RMNCAH on some key RMNCAH indicators against the national average.

Table 2.1: Key RMNCAH indicators in six targeted counties against the national average

Indicator	Isiolo	Lamu	Mandera	Marsabit	Migori	Wajir	Kenya
Pregnant women attending at least four ANC visits (%)	66	80	53	49.3	60	38	58
Births attended by skilled health personnel (percentage)	87	90	51	68.7	80	51	62
Maternal Mortality Ratio	790	676	3,795	1,127	673	1,683	488
Women of reproductive age living with HIV on antiretroviral treatment (percentage)	60	1,415*	5	57	99	8.3	
Percentage of pregnant women tested for HIV and received their results	18	42.5	80	12	7	28.3	76
Vaccination coverage among 12-23 months children	82.3	67.4	42.7	67.5	57.2	49.5	74.9
Neonatal mortality rate[9]	27	32	35	63	18	30	22
U5 mortality rate[10]	49	72.1	32.5	36.4	121.1	46.6	52
HIV prevalence[11]	3.2	3.0	0.2	1.4	13.3	0.1	6.3

***Source**: KDHIS 2014 and UN H6 Joint Programme document*

Kenya's economy is the most developed and diversified in East Africa with main economic drivers being agriculture, service delivery and industry contributing to **34 percent**, **45 percent**, and **17 percent** of GDP respectively.

9 https://www.equist.info/en/pages/dashboard

10 Sub national variation and inequalities in under-five mortality in Kenya (2013) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6360661/

11 NACC Kenya HIV Estimates Report 2018

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Only 58%

of expectant mothers completing the recommended four antenatal care visits

KDHS 2014

2.2.1 Maternal Health

Kenya has shown encouraging improvements in maternal health outcomes since 2003 to 2020, but maternal mortality still remains a challenge with 362 maternal deaths per 100,000 live births[12], but it fell short of MDG target of 147/100,000 by 2015 and still falls short of SDG 3 target 3.1 of 70/100,000[1314]. However, the significant improvement in outcomes is not homogenours across all the counties. For instance, in 2009, the national MMR (Maternal Mortality Ratio) was 488/100,000 while the county estimates ranged from 3,795 in Mandera County to 187/100,000 in Elgeyo Marakwet County (PSRI, 2014). The latest national MMR is 362/100,000 (KDHS,2014) and 488/100,000 in 2009[15]. Of the 47 counties, only about 15 account for 98.7 percent of all maternal deaths in the country[16].

The high MMR in Kenya is largely due to limited access to and low uptake of skilled care, with only 58 percent of expectant mothers completing the recommended four antenatal care visits, 62 percent receiving skilled care at delivery and 53 percent receiving postnatal care within 2 days of giving birth[17,18]. Multiple reasons contribute towards women not taking up services that are available including significant gaps that exist in service provisions. There is inadequate implementation of existing policies, guidelines and protocols and poor monitoring due to health system weaknesses. The other reason for the high MMR is the low BEmONC coverage in Kenya which currently stands at 41 percent, with only with only 7 percent of facilities being able to offer all the services including CEmONC[19]. Major hindrances to the provision of basic lifesaving obstetric and newborn care are limited equipment and supplies, regular stock-outs of the essential obstetric and neonatal and lack of technical know-how among health care workers, especially in lower-level facilities (health centres and dispensaries).

Utilisation of modern contraceptive methods has increased markedly over the last decade from 32 percent in the 2003 KDHS to 53 percent in 2014,[20] but with wide disparities around the country. This is reflected in significant differences in county fertility rates that varies

12 https://data.worldbank.org/indicator/SH.STA.MMRT?locations=KE

13 Kenya Demographic and Health Surveys 2014 and 2008/9

14 Sustainable Development Goals

15 UNFPA/University of Nairobi Population Studies and Research Institute (2014): *Situational Analysis Report on Ending Preventable Maternal Mortality in Kenya*

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

17 Kenya Demographic and Health Survey 2014

18 UNICEF Kenya Key Demographic Indicators/ https://data.unicef.org/country/ken/

19 MOH: *Service Availability and Readiness Assessment Mapping Report, 2013*

20 Kenya Demographic and Health Surveys 2014

from a low of 2.3 births per woman in Kirinyaga County a high of 7.8 in Wajir County[21]. However, the national total fertility rate in Kenya declined from 4.6 in 2008/2009 to 3.9 in 2014. Estimates indicate that family planning may contribute indirectly to the prevention of up to 40 percent of maternal and newborn deaths[22]. Challenges affecting optimal utilization of family planning include socio-cultural factors; inadequate resource allocation to family planning commodities; inadequate capacity to quantify and forecast family planning needs; weak supply chain management; and inadequate capacity at the facility level to provide comprehensive family planning services, particularly long-acting and permanent methods[23]. There are also policy challenges regarding family planning service delivery at the community level and weak data capture and poor utilization of data.

The Government has introduced new policies such as Universal Health Coverage that is in the pilot phase in four counties with the aim of addressing critical barriers to access and utilisation of RMNCAH services. Other initiatives by the government include Linda Mama Programme (Free Maternity Services) through the National Hospital Insurance Fund (NHIF), and 'Beyond Zero Initiative' being spearheaded by the First Lady aimed at ensuring that no woman should die while giving life. As much as this confirms Kenya's commitment to ensuring SDG 3 is achieved, challenges especially in access, quality and utilisation of essential RMNCAH services still remain.[24].

2.2.2 Neonatal Health

Globally, remarkable progress has been made in ensuring child survival in the past few decades, and millions of children have better survival chances than in the 1990s when 1 in 26 children died before reaching age five in 2018, compared to 1 in 11 in 1990[25]. Despite the global progress in reducing child mortality over the past few decades, an estimated 5.3 million children under age five (U5) died in 2018 with roughly half of those deaths occurring in Sub-Saharan Africa from major causes that are preventable. The neonatal (newborn) mortality rate in Kenya has also declined in the last decade. Recent estimates by UNICEF suggest that infant in Kenya dropped to 41 per 1,000 live births in 2018 from 52 in KDHS 2014[26]. The decline has been driven mainly by the enhanced use of mosquito nets, increased utilisation of antenatal care, skilled attendance at childbirth, postnatal care, contraceptive use, exclusive breastfeeding practices, and a decrease in unmet family planning needs, as well as overall improvements in other social indicators such as education and access to water[27].

The neonatal mortality rate declined marginally from 22 deaths per 1,000 births to 20 between 2014 and 2018[28] However, much more is required to achieve SDG 3 target of 12 per 1,000 live births by 2030. It is notable that more than 56 percent of infant deaths may be occurring within the neonatal period[29]. Further reductions in infant and child mortality require a steeper decline in the neonatal mortality rate, which is closely linked to improvements in maternal health services, including intrapartum care. Current estimates suggest that only 36 percent newborns have a postnatal contact with a health provider within 2 days of delivery leaving many newborns with long-term disabilities that impact negatively on their quality of life.

As a result, there is an urgent need to ensure that mothers and their children are provided with comprehensive services to prevent mother-to-child transmission of HIV, primary health care, and social support. More investment is required to ensure that fewer infections occur in children as a result of mother-to-child transmission of HIV. Some efforts including Maternal and Newborn Health Scale-up Plan) under the umbrella of the 'Every Newborn Every Mother' initiative which includes Kangaroo Mother Care and Community Health Strategy have been made but there is a need to scale up and sustain the efforts.

21 Ibid

22 Byrne et al. (2012): 'Context-specific, Evidence-based Planning for Scale-up of Family Planning Services to Increase Progress to MDG 5: Health Systems Research', *Reproductive Health*, Vol. 9, p. 27.

23 ibid

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

25 UNICEF: Under 5 mortality/ https://data.unicef.org/topic/child-survival/under-five-mortality/

26 Ibid

27 Kenya Ministry of Health (2015): Kenya RMNCAH Investment Framework.

28 UNICEF: Under 5 mortality/ https://data.unicef.org/topic/child-survival/under-five-mortality/

29 Mwaniki et al. (October 2010): 'An Increase in the Burden of Neonatal Admissions to a Rural District Hospital in Kenya over 19 Years', BMC Public Health, DOI: 10.1186/1471-2458-10-591

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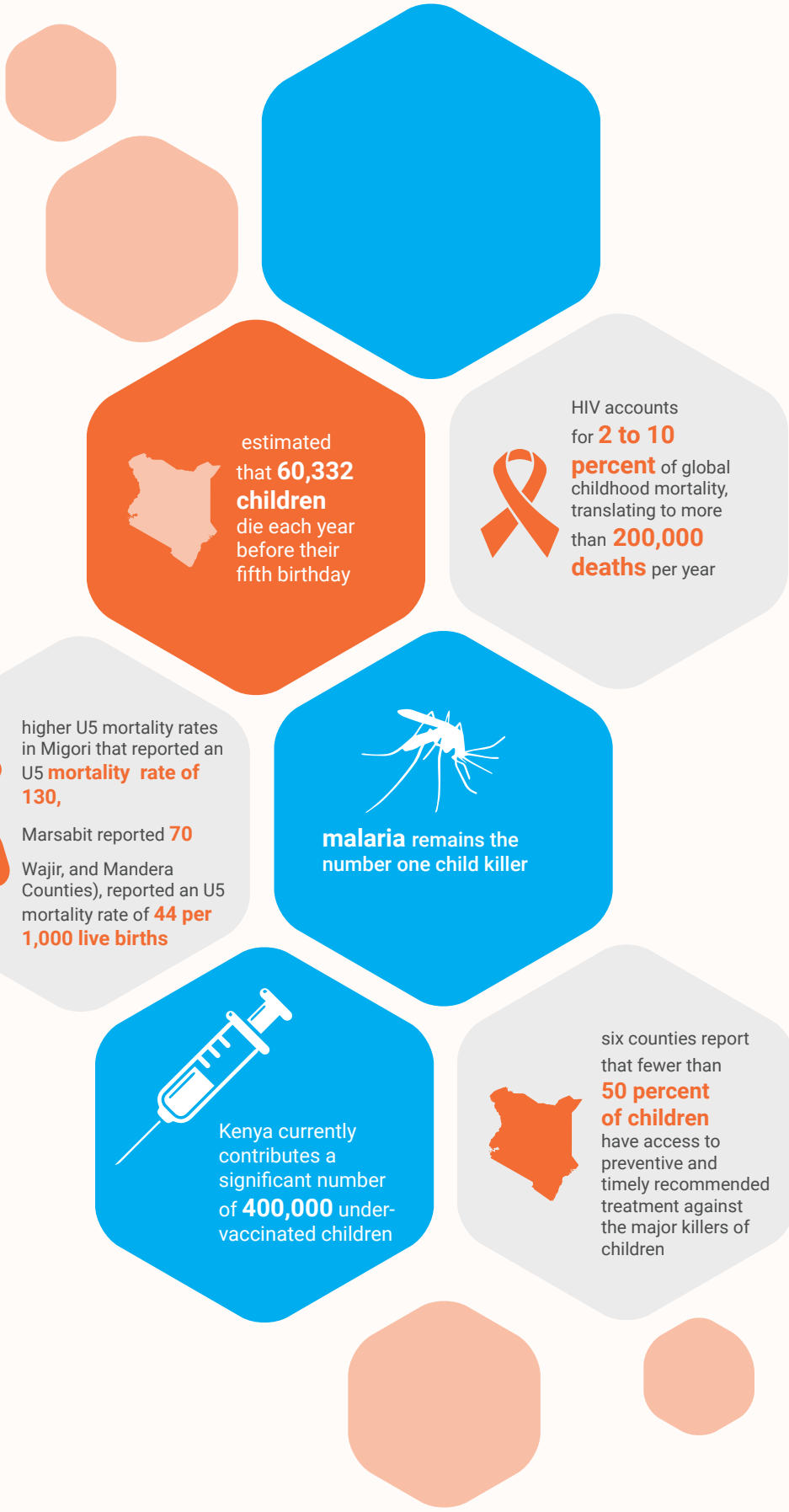
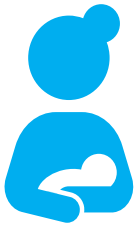
CHILD MORTALITY



2.2.3 Child Health

Major causes of 5.3 million deaths among children under five globally are largely preventable. Presently, HIV accounts for 2 to 10 percent of global childhood mortality, translating to more than 200,000 deaths per year. This proportion is as high as 27–42 percent in countries with a high HIV burden[30]. It is estimated that 60,332 children die each year before their fifth birthday in Kenya. The U5 mortality rate reduced to 41 per 1,000 live births in 2018 from 52 in KDHS 2014[31]. However, like most other RMNCAH indicators, disparities exist among the counties, with higher U5 mortality rates in western Kenya especially Migori that reported a rate of 130, whereas Marsabit reported 70[32]. In the north-eastern region (Garissa, Wajir, and Mandera Counties), reported an U5 mortality rate of 44 per 1,000 live births[33].



Presently, HIV accounts for **2 to 10 percent** of global childhood mortality, translating to more than **200,000 deaths** per year

It is estimated that **60,332 children** die each year before their fifth birthday in Kenya

In six counties that were targeted by the JP on RMNCAH programme, U5 mortality remains very high, with the majority of deaths caused by pneumonia and diarrhoea (in some localities especially Migori, malaria remains the number one child killer). As a country, Kenya currently contributes significant number of under-vaccinated children (400,000); of these children, the six counties contribute about 13 percent[34]. The six counties report that fewer than 50 percent of children have access to preventive and timely recommended treatment against the major killers of children along the continuum of care.

There is therefore a need to increase and sustain investment in child health interventions that will address health system challenges that hinder access to preventive and curative actions against major killers of U5s. It is crucial to maintain and consolidate existing highly effective and high-impact child health interventions. These include the introduction Zinc and oral rehydration solutions for diarrhoea, Amoxicillin Dispersible Tablets (Amox DT) for the treatment of paediatric pneumonia[35], and malaria case management. Strategies to improve child health include Integrated Management of Childhood Illnesses, integrated Community Case Management of Childhood Illnesses, and demand generation, as well as supplementing anti-malaria activities, including using social mobilization platforms.

2.2.4 Adolescent Health

Adolescents aged 10-19 constitute about 24 per cent of the country's population[36] in Kenya. Adolescents and young people, as in the rest of the continent, are faced with significant vulnerabilities and challenges to their health and general well-being. These include early and unintended pregnancies, child marriage, unsafe abortions, female genital mutilation (FGM), sexual and gender-based violence, and sexually transmitted infections, including HIV.

30 Black, Robert E. et al. (2013): 'Maternal and Child Undernutrition and Overweight in Low-income and Middle-income Countries', The Lancet, Vol. 382, No. 9890, pp. 427–451.

31 UNICEF: Under 5 mortality/https://data.unicef.org/topic/child-survival/under-five-mortality/

32 Multiple Indicator Cluster Survey 2011 and 2008

33 Kenya Demographic and Health Survey 2014

34 UN H6 Joint Programme document

35 UNICEF, Amoxicillin Dispersible Tablets: Market and Supply Update, 2018

36 2019 Kenya Population and Housing Census (KPHC).

Teenage pregnancy remains a significant health and social concern, due to association with higher maternal and child morbidity and mortality[37]. It's estimated that 1 in every 5 girls between 15-19 years in Kenya is either pregnant or already a mother[38] with 82 births per 1,000 births being as a result of teen pregnancy making Kenya the third-highest country with teen pregnancy rates according the Global Childhood Kenya. Social consequences of unintended pregnancies in Kenya include girls dropping out of school, with estimation of 13,000 girls dropping out of school annually[39]. Teenage pregnancy 2019 estimates in the six target counties indicate Migori has the highest number (about 12,000) of adolescents aged 10 – 19 years presenting with pregnancy at health facilities while Lamu has the lowest at about 1180[40]. Isiolo county had about 3200, Mandera 5200 while Wajir had 2900 according to the 2019 estimates[41]. The COVID-19 pandemic containment measures especially closure of learning institutions had worsened the teenage pregnancy situation in Kenya including in the six targeted counties according to recent media reports[42].

1 in every 5 girls between 15-19 years in Kenya is either pregnant or already a mother with **82 births per 1,000 births being** as a result of teen pregnancy

Over 13,000

girls drop out of school annually as a result of unintended teenage pregnancy

Despite of the high incidence of teenage pregnancy, access to youth friendly services including family planning and other sexual and reproductive health services for adolescents and young people is still a challenge in general partly due to limited sexuality education in schools and low coverage of youth friendly health services with only 62 and 17 percent of facilities offering adolescent health services and services for victims of youth violence respectively. While overall incidence of new HIV infections has continued to decline, young people (15-24) still account for 39 percent of new infections in Kenya, despite a 40% reduction in new HIV infections among young persons aged 15-24 years from 2013 to 2017; 46% and 58% in young women & young men respectively[43].

There is an urgent need to address the drivers of teenage pregnancy that include cultural, religious, and socio-economic factors that contribute to the high teenage pregnancy rates especially in some of the programme counties. It is notable that efforts to address teenage pregnancies and other sexual and reproductive health matters are resisted by parents, religious leaders, political leaders and other stakeholders despite the mounting evidence that young people are initiating sex earlier than in the past. Even nationally, interventions like appropriate sexuality education targeting teenagers are also often dismissed with the view that they would encourage young people to indulge in sex.

Kenya has put in place adequate measures to ensure an enabling policy environment for the promotion and realization of SRH of adolescents and young people including response to key health concerns such as teenage pregnancy, HIV and AIDS and SGBV (Sexual and Gender Based Violence). This includes the draft Reproductive Health Bill 2019; National Adolescent Sexual and Reproductive Health Policy (2015); National Guidelines for the provision of Adolescent and Youth Friendly Services (2016); The Kenya AIDS Strategy Framework (KASF) 2014/15-2018/19; the Education Sector Policy on HIV and AIDS (2013) and the Fast-track Plan to end HIV and AIDS among Adolescents and Young People (2015). More effort however still needs to be put in place to ensure implementation and operationalization of these frameworks.

37 Ibid

38 Kenya Data and Health Survey 2014

39 National ASRH Policy 2015

40 https://www.afidep.org/publication/adolescents-age-10-19-presenting-with-pregnancy-at-health-facilities/

41 Ibid

42 https://reliefweb.int/report/kenya/covid-19-lockdown-linked-high-number-unintended-teen-pregnancies-kenya

43 Kenya NACC (2018): Kenya AIDS Response Progress Report, 2018

2.2.5 Gender-based Violence

Women and young girls in Kenya are particularly vulnerable to gender-based violence with about 41 percent of ever-married women aged 15–49 years having experienced physical or sexual violence[44]. Among ever-married women, the most reported perpetrators of sexual violence are current spouses/partners (55 percent). The KDHS 2014 survey also found that 21 percent of Kenyan women have undergone female genital mutilation. Consistent with other health indicators, there is regional variations in the experience of sexual violence across the country with the north-eastern region, which includes five of the six counties in which the JP on RMNCAH was implemented, sexual violence reports are among the lowest, accounting for less than 1 percent of cases. However, anecdotal evidence would suggest that this is a gross under-representation of the magnitude of the problem.

41%

of ever-married women aged 15–49 years having experienced physical or sexual violence

GBV in Kenya is fuelled by mainly by socio-cultural dynamics that contribute to normalize and condones GBV, as well as slow and uneven enforcement of anti-GBV laws and policies. These factors often contribute to or fuel the spread of harmful cultural practices such as female genital mutilation/cutting, early and forced marriage, sexual violence, and other forms of gender-based violence. Gaps exist in providing comprehensive services to survivors of GBV. There are only a few locations where GBV survivors can access services from key sectors (e.g. health, security, psychosocial, and legal) through a single referral. Translating the known linkages between gender inequality and sexual reproductive health rights concerns, including GBV and HIV, into practical programming in support of survivors and people living with HIV and AIDS remains a challenge in Kenya.

In line with the provisions of the national guidelines for the management of survivors of sexual violence (revised 2012), the Government of Kenya has made significant progress in addressing the needs of survivors of violence. There are a small number of health facilities in Kenya where survivors can get free and immediate HIV testing and counselling, post-exposure prophylaxis, emergency contraceptive pills, and prophylaxis and treatment for sexually transmitted infections. The facilities also collect samples for medico-legal interventions, which includes filling in of the Post-Rape Care Form. These facilities thus promote a holistic approach to service delivery for survivors of sexual violence, tailored to their needs and underpinned by principles of dignity and respect.

However, gaps related to health worker capacity to manage SGBV and poor linkages among sexual violence and GBV service providers still exist, especially in the public sector. Under-reporting of GBV cases, inefficient data collection and management, and inadequate case management and service provision for survivors make it difficult to collect accurate information on the prevalence of the problem. Without accurate data, the proper costing and budgeting of services for GBV survivors continues to be underestimated, and this situation reduces the possibility of services reaching all those in need.

44 Kenya Demographic and Health Survey 2014

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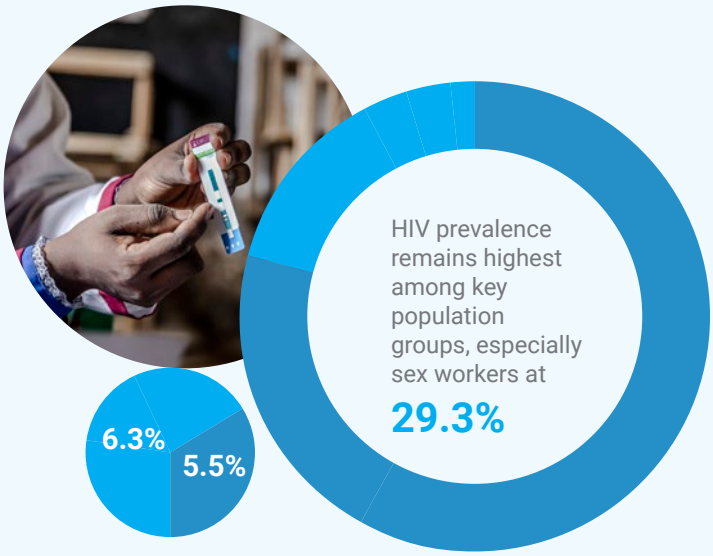
2.2.6 HIV and AIDS

Kenya is one of the six HIV 'high burden' countries in Africa, with an average prevalence of about 6 percent, a total 1.5 million people living with HIV, and 52,800 new infections in 2018[45]. The epidemic is deeply rooted among the general population, though there is high geographical variability of the HIV burden – ranging from less than 1 percent prevalence in the northern arid and semi-arid areas to a prevalence of over 20 percent in some counties in the former Nyanza Province. Nationally, HIV prevalence remains highest among key population groups, especially sex workers at 29.3 percent[46]. Women in Kenya are more vulnerable to getting HIV infection than men, with a national HIV prevalence of 6.3 percent against 5.5 percent. The high burden of HIV and AIDS in Kenya accounts for 28,200 annual adult deaths[47]. Furthermore, AIDS-related deaths account for one-fifth of maternal mortality, and one-sixth of deaths among children under the age of five, with 5,000 annual deaths. HIV infection in pregnancy increases the risk of miscarriage, anaemia, post-partum haemorrhage, puerperal sepsis, and post-surgical complications, as well as the risk of tuberculosis and malaria infection. Among young people (aged 15–24), AIDS is the leading cause of death, resulting in 2,830 deaths in 2017. A total of 17,667 young people acquired HIV in 2017 (39 percent of all new adult infections), with 12,500 infections in young women and 5,200 infections in young men.

HIV prevalence is low (0.1- 4.5 %) in five of the six UN H6 RMNCAH Programme implementing counties with Migori being an exception where prevalence is around 14 %. Wajir has a HIV prevalence of 0.1 percent, Mandera 0.2 %; Marsabit 1.4 %; Isiolo 3.2% and Lamu 3 %. While the prevalence is low in the five other counties, the mother-to-child transmission rate is notably higher, especially Wajir with MTCT rate of 32.7% compared to national prevalence of 11.5%[48]. ART coverage is also low, resulting in a high number of HIV-related deaths relative to the number of people living with HIV. Major gaps in HIV response include high unmet need in HIV testing, low contraceptive (especially condoms) uptake, sub-optimal focussed antenatal clinic attendance rate and skilled delivery, high HIV stigma index, and ART unmet need among children and adults respectively. Other major drivers to HIV epidemic especially in Mandera include high illiteracy levels, early marriages and FGM cultural practices[49] while in Marsabit are high poverty levels, low sexual risk perception and inability to negotiate for safer sex among women, intergenerational sex, early sexual debut, and drug/substance abuse[50].

Kenya has an average prevalence of about **6 percent,** a **total 1.5 million** people living with HIV, and **52,800 new infections** in 2018



Women in Kenya are more vulnerable to getting HIV infection than men, with a national HIV prevalence of **6.3 percent** against **5.5 percent**

45 Kenya NACC (2018): Kenya AIDS Response Progress Report, 2018

46 Ibid

47 Ibid

48 Ibid

49 Mandera County HIV and AIDS Strategic Plan 2016-2019: A healthy and productive population

50 Marsabit county HIV & AIDS strategic plan 2015/2016 - 2018/2019

While still high, AIDS-related deaths have decreased in the past few years. This decrease is directly attributed to the wider and easier access to antiretroviral therapy (ART).

The ART programme has scaled up tremendously since 2008: the number of adults living with HIV on ART has increased from 238,000 to almost 1,035,615, which was 75% ART coverage in 2018. Impressive gains have also been made on biomedical interventions, particularly the prevention of mother-to-child transmission (MTCT) of HIV. This coverage has increased to 76 percent. However, the MTCT increased to 11.5 percent in 2017 from 8.3% in 2015. More intensified efforts are however necessary to eliminate mother-to-child transmission[51].

In 2009 government launched the National Reproductive Health and HIV and AIDS Integration Strategy aimed at linking Reproductive Health and HIV and AIDS policies, programmes, and services by improving coordination and collaboration among key agencies and organisations offering RH (Reproductive Health) and HIV and AIDS services. In 2013, Kenya launched the Prevention Revolution Roadmap to End New HIV Infections by 2030. The country also developed the Kenya AIDS Strategic Framework (KASF) 2014/2015-2018/2019. And therefore between 2013 and 2017 alone, the country realised 28% reduction in new HIV infections identified among pregnant women (including prior positives). Between 2011 and 2017, the country also realised 38% reduction in new HIV infections among children aged 0-14 years and 52% reduction in number of AIDS related Deaths. It also realised a further 40% reduction in new HIV infections among young persons aged 15-24 years from 2013 to 2017[52].

Kenya has been a pioneer in the integration of services. However, efforts still need to be scaled up. Opportunities exist for the integration of HIV and RMNCAH services and the promotion of better linkages. These relate to prevention of mother-to-child transmission, antiretroviral therapy, and strengthening linkages between HIV and reproductive cancer screening.

2.3 COVID-19 Pandemic effect on RMNCAH, HIV and GBV services

The COVID 19 pandemic has had a significant effect on RMNCAH, HIV and GBV services. Since the first COVID-19 Case was reported on 13th March 2020 and, the confirmed numbers have increased exponentially despite several stringent measures put by the national and county governments. The continued spread of the COVID-19 has impacted negatively on the provisions and utilisation of essential health services including RMNCAH, HIV and GBV as the focus and efforts shifted towards controlling its spread[53]. Most significantly, the COVID-19 spread has impacted on the number of patients including women and children visiting health facilities which has been further worsened by the stigmatisation of COVID-19 patients. The national MOH reports indicate that many patients avoided visiting health care facilities especially in April and preferred to remain at home for fear of being exposed since the advent of COVID-19.

Overall, most RMNCAH indicators for January – June 2020 period are much lower than data of the same period in the previous two years. For example, there was a notable decline in HIV testing between Jan-May 2020 compared to the same period in the previous years, 2018 and 2019; a 36% drop in OPD visits between February and May 2020; and a decline in utilization of outpatient care by children below 5 years of more than half (56%) between February and May 2020[54]. The number of GBV cases reported during the COVID 19 pandemic has increased as a direct result of COVID related mental anguish, confinement, and financial constraints. The strict containment measures by the government have also had a negative impact on women and girls, including elevating the risk of gender-based violence which has also resulted in a significant spike in sexual offences[55].

51 Framework for Elimination of Mother to-Child Transmission of HIV and Syphilis 2016–2021

52 Kenya NACC (2018): Kenya AIDS Response Progress Report, 2018

53 COMESA: COVID-19 Pandemic and its Potential Impact on The Health Sector in the COMESA Region https://www.tralac.org/documents/resources/covid-19/regional/3700-covid-19-pandemic-and-its-potential-impact-on-the-health-sector-in-the-comesa-region-special-report-may-2020/file.html

54 MOH: Impact of COVID-19 on Essential Health Services in Kenya, July 2020.

55 http://ncaj.go.ke/statement-on-justice-sector-operations-in-the-wake-of-the-covid-19-pandemic/

2.4 Policy Environment

RMNCAH service provision is a priority for the GOK and is emphasized in its Vision 2030, the 2010 Constitution of Kenya, and the Health Sector Strategic and Investment Plan 2014–2018. Vision 2030 is the Kenya's development roadmap covering the period 2008 to 2030 and is based on three pillars: the economic pillar, the social pillar and the political pillar. The current

Third Medium Term Plan (MTP III) 2018-2022 also has a social pillar with a component on health with particular focus on the achievement of Universal Health Coverage by implementing programmes that increase health insurance coverage, increase access to quality healthcare services including RMNCAH and offer financial protection to people when accessing healthcare. Some of the policies and initiatives the government introduced are:

1. **Kenya Health Policy 2014-2030**[56] supports implementation of various MTP III priorities in the Health Sector to address prevention, diagnosis and treatment leading to universal health care. The Government committed to facilitate implementation of programmes and projects that will lead to the attainment of Sustainable Development Goal (SDG) No. 3 (Ensure healthy lives and promote well-being for all at all ages) and aspiration of Africa's Agenda 2063.

2. **Kenya RMNCAH Investment Framework** which outlines the RMNCAH vision and priority areas for investment and action to be taken at national and/or county level to ensure that affordable evidence-based and high-impact interventions are delivered to improve RMNCAH results.

3. **The Kenya AIDS Strategic Framework 2014/15–2018/19**[57] which addresses the drivers of the HIV epidemic and builds on the achievements of previous country strategic plans to achieve its goal of contributing to the country's Vision 2030 as well through universal access to comprehensive HIV prevention, treatment, and care. This framework was adopted and contextualised by all the 47 counties.

4. **The Kenya Framework for Elimination of Mother-to-Child Transmission of HIV and Syphilis 2016–2021** which aims to facilitate Kenya's validation for the pre-elimination of mother-to-child transmission of HIV and syphilis by 2011, as per WHO guidelines.

5. **The National Policy for Prevention and Response to Gender-based Violence** which aims to accelerate efforts towards the elimination of all forms of GBV in Kenya, and provides an implementation framework that spells out the roles and responsibilities of all stakeholders, and further recognizes the functions of the two levels of government along accountability, reporting, and management lines.

56 Republic of Kenya, Ministry of Health (2014): *Kenya Health Policy 2014–2030: Towards Attaining the Highest Standard of Health.*

57 National AIDS Control Council/Ministry of Health (2014): Kenya AIDS Strategic Framework 2014/2015–2018/2019.

2.5 Health System Gaps and Obstacles

Despite the documented improvements in access, quality, and utilisation of RMNCAH services, the Kenya health System is still experiencing major challenges. The remaining gaps and obstacles are numerous and can be grouped into four main areas[58]:

1. Inequitable coverage among certain areas or population groups, including adolescents requiring well targeted additional investments.

2. Demand side barriers that limit access and utilization of proven high impact interventions to realize Kenya's RMNCAH vision. These include long distances to health facilities, high costs, religious and sociocultural beliefs and practices and low status of women as well as lack of knowledge and information. The demand side barriers get further compounded by provider attitudes, poor quality and limited integration of services that also hamper and discourage utilization of services.

3. Supply side challenges due to suboptimal functioning of the health systems (infrastructure, human resources for health (HRH), supply chain, health financing, health Information, and leadership/ governance). The main health system challenges include poor workforce distribution and productivity coupled with funding gaps and weak supply chain management for provision of essential RMNCAH commodities; incomplete and poor quality of data from routine health information systems that hamper evidence-based decision making and accountability for results; inability to optimize the devolution dividend and make effective use of resources from both domestic and partners due to capacity challenges and weak coordination at national and county levels.

4. High burden of HIV and AIDS and related mortality and morbidity.

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58 Kenya Ministry of Health (2015): Kenya RMNCAH Investment Framework.

Chapter
03

UN H6 joint programme on RMNCAH

3.1 UN H6 Partners Strategic Response

The aim of United Nations Development Assistance Framework (UNDAF) is to integrate the global programming principles and approaches of: leave no one behind; human rights, gender equality and women's empowerment; sustainability and resilience; and accountability towards realization of social development goals (SDGs) [59]. The 5th generation of UNDAF (2018-2022) for Kenya, developed in collaboration with the Government of Kenya as the host and key implementing partner, is aligned to Kenya's Vision 2030 and national/county priorities as defined in the third Medium Term Plan (MTP III). This framework expresses commitment of the United Nations (UN) to support the people of Kenya realize their development agenda. Consequently, the UN H6 JP on RMNCAH in Kenya is implemented within the framework of the 2018-2022 Kenya United Nations Development Assistance Framework with significant contribution to UNDAF priority number 2 (Human capital development comprised of education, training and learning, health, Multi-sectoral HIV and AIDS response, access to safe water and sanitation, social protection, gender based violence and violence against children, access to adequate housing and strengthening capacities for addressing disaster and emergencies). The H6 Partnership harnesses the collective strengths of UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank Group to support country leadership, Every Woman Every Child (EWEC) movement, and action in advancing the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030 and reaching the targets of the health-related Sustainable Development Goals (SDGs).

3.2 The UN H6 Programme on RMNCAH

The Joint Programme on RMNCAH is a collaborative initiative between the Government of Kenya and UN H6 partners (UNAIDS, UNFPA, UNICEF, WHO, UN Women, and the World Bank), working together towards the reduction of preventable maternal, newborn, and child deaths in six high-burden counties in Kenya during the period July 2015 to December 2020. This programme is aligned to Kenya's national Reproductive Health Strategy 2009-2015, and contributes to the country's national development plans and goals with key focus on reproductive health and adolescent health as well as HIV and gender as reflected in Vision 2030, the Constitution of Kenya 2010 and the Health Sector Strategic Plan 2018-2022 and the

59 United Nations Development Assistance Framework (UNDAF) 2018-2022

Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Framework. It further supports the country in its efforts to adhere to international commitments on protecting reproductive health rights and child rights.

3.2.1 RMNCAH Program funding

The first phase of RMNCAH programme funding came from the Reproductive, Maternal, Newborn, and Child Health (RMNCH) Trust Fund[60]. The trust fund was established in 2013 by UNICEF, UNFPA, WHO, and development partners as a global-level funding mechanism designed to finance high-impact, priority interventions that countries had already included in their reproductive, maternal, neonatal, and child health plans, in order to accelerate the reduction of maternal and child deaths[61]. The Department for International Development of the United Kingdom and the Government of Norway have been pooling resources in the trust fund. The total RMNCH Trust Fund grant was US$ 14.9 million aimed at supporting prioritized activities to address bottlenecks and gaps on reducing preventable maternal and newborn deaths in the aforementioned six high maternal mortality burden counties. The funding was channeled through UNFPA, UNICEF and WHO.

The second phase of UN H6 RMNCAH programme was co-financed between the government of Denmark, the UN H6 Partners, and the government of Kenya. The Danish support is provided within the framework for thematic programme on health, one of the three thematic programmes under the Danish Country Programme for Kenya 2016-2020. The Government of Denmark contributed DKK 40 million (equivalent to USD 6 million) whereas the UN H6 Joint Programme participating agencies cumulatively contributed USD 14.4 million. The Government of Kenya contributes in kind by making available human resources, infrastructure, equipment, and commodities within the public health system in the six programme counties. UNFPA is the programme administrative and convening agent whereas other UN agencies (UNICEF, WHO, UNAIDS and UN Women) are programme participating agencies. The World Bank provides technical support to the programme but does not receive any programme funds for implementation. Additionally, the programme leverages on the support of other programmes implemented by UN H6 and other agencies – with funding from UN core resources or development partners and also of public–private partnerships such as the Private Sector Health Partnership Kenya.

3.2.2 Evolution of the programme over time

The Kenya JP on RMNCAH has evolved over time from phase one to phase two of programme implementation. The first phase of the RMNCAH programme was implemented in six high-burden counties (Mandera, Marsabit, Wajir, Isiolo, Lamu, Migori) in Kenya between March 2015 and September 2016. The activities were implemented between July 2015 and December 2016 by the County Departments of Health, Liverpool School of Tropical Medicine (LSTM), National Council for Population and Development (NCPD), the Kenya Red Cross (KRCS) and AMREF Health Africa. The RMNCH Trust Fund support came to an end in December 2016.

The second phase of the UN JP on RMNCAH commenced in January 2017 and runs up to December 2020. This was implemented in the same six high maternal and new born mortality burden counties of Mandera, Marsabit, Wajir, Isiolo, Lamu and Migori. The second phase of implementation leveraged on successes from the first phase to offer continued support towards reduction of maternal and newborn mortality in the same six high burdened counties in Kenya. The JP is results based and ensures the integration of gender equality and human rights considerations throughout implementation, thereby ensuring a right and equity-based approach to addressing the identified disparities. Throughout the implementation, this JP focusses on evidence-based, equitable, and efficient high-impact interventions that will contribute to the long-term sustainability of the results achieved.

3.2.3 Programme outcome areas

The overall goal of the UN JP on RMNCAH is that, by 2020, six counties with high maternal mortality burden (Mandera, Marsabit, Wajir, Isiolo, Lamu, Migori) will enjoy increased utilization of integrated, quality reproductive,

60 UN H4+ agencies (2014): *Improving Maternal and Newborn Outcomes in Six High Burden Maternal Mortality Counties in Kenya: Isiolo, Lamu, Mandera, Marsabit, Migori, and Wajir*, December 2014.

61 The Department for International Development of the United Kingdom and the Government of Norway.

maternal, newborn, child, and adolescent health, HIV, and gender-based violence (GBV) services, to contribute to the reduction of maternal and newborn mortality in Kenya. The three key outcomes are:

1. Improved access to, and quality of, integrated RMNCAH, HIV, and GBV services
2. Increased demand for quality RMNCAH, HIV, and GBV services
3. Strengthened institutional capacity at county and national levels for planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services

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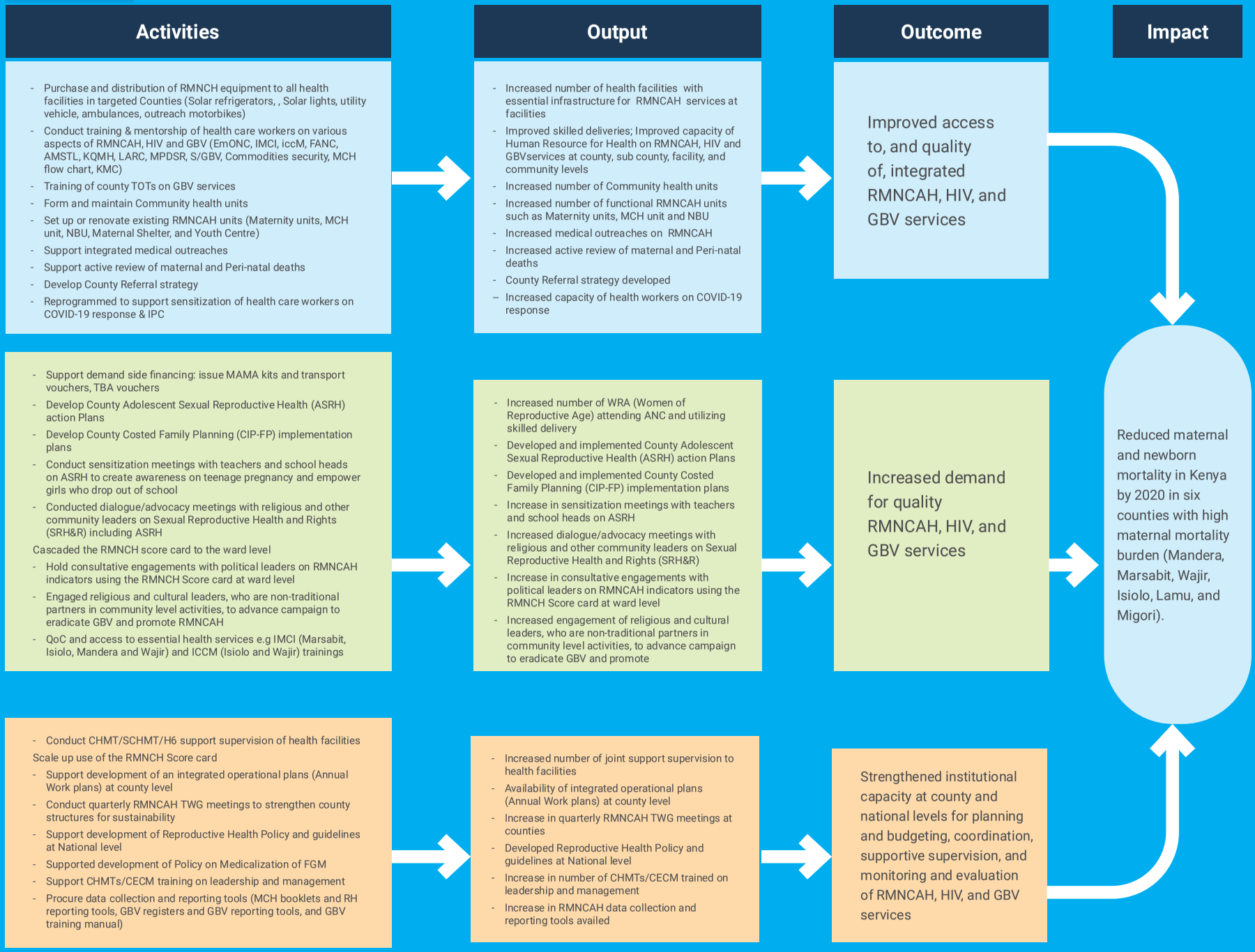
3.2.4 Intervention Logic

FIGURE 3.1: Intervention Logic

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Chapter
04

Findings

4.1 Introduction

This section presents the findings of the evaluation as they relate to its five evaluation questions (EQs). The evaluation was based on the framework established by the OECD-DAC evaluation criteria. Using these criteria, the project was assessed for relevance, effectiveness and strategic alignment, efficiency, sustainability and coordination and partnership. The findings are organised by EQs. The detailed evidence base for the evaluation findings is provided in the matrix (Annex IV).

4.2 Evaluation Question 1: Relevance

1. To what extent is the RMNCAH programme adapted to national and county needs and policies?

2. To what extent did the UN RMNCAH JP address needs and priorities of beneficiaries including women of reproductive age, girls, adolescents, young people, vulnerable people, and indirectly healthcare providers? How valuable were the results to beneficiaries?

3. Has the H6 RMNCAH programme been able to adequately respond to changes in needs and priorities, and to specific requests from the national and county stakeholders?

The UN H6 programme was evaluated to measure the extent to which the RMNCAH programme is adapted to international development goals (SDGs), national and county needs and policies, addressed needs and priorities of beneficiaries, and if it adequately responded to changes in needs and priorities, and to specific requests from the national and county stakeholders. This evaluation established that the UN H6 JP is relevant to the needs of target direct and indirect beneficiaries, Kenya's strategic plans (including county strategic plans), county and country priorities, UNDAF, and international development goals (SDGs).

UN global call and alignment to SDGs

The UN Secretary-General's, *Every Woman Every Child* global strategy launched 2010 aims to intensify national and international commitment and action by governments, the UN, multilaterals, private sector and civil society to keep women's, children's and adolescents' health and wellbeing at the heart of development. The UN JP came in to contribute towards this global strategy in ensuring

that all women, children and adolescents in the six selected counties not only survive, but also thrive to their full potential to help transform the world. This evaluation found that the UN H6 joint programme is aligned to and relevant to SDGs 3 and 5. Critical top line indicators for SDG 3 and 5 on maternal mortality, child and new-born health were directly responded to by the UN JP under review.

Alignment to Kenya country needs and priorities

The UN H6 JP, whose mandate is anchored around UNDAF is aligned to Kenya's Vision 2030, the Medium-Term Plan III (2018-2022), and the RMNCAH Investment Framework 2016. The JP contributes to the realization of UNDAF outcomes. The Kenya RMNCAH investment framework was formulated for implemented in 2014/2015. This is a strategic document that the ministry of health in Kenya is using to respond to the RMNCAH situation in the country. The UN H6 joint program on RMNCAH was a direct response to the gaps contained therein, especially in the six most affected counties lagging behind when compared to other counties generally doing well. The UN JP program targeted 6 of the 15 high burden counties. The JP is also aligned to the Kenya AIDS Strategic Framework (KASF) 2014/15-2018/19 and to the National Policy on prevention and Response to Gender Based Violence (2014). The JP addressed the most pertinent RMNCAH/HIV and GBV needs especially on family planning, deliveries, maternal and child health, renovation, equipment and institutional capacity building to clinical health care workers, CHVs and TBAs. The program fitted well in the existing gaps with key indicators lagging behind as demonstrated by one of the respondents.

> *…..the project is very relevant to this county and its people. Considering some of our key indicators. Skilled delivery, family planning coverage, four ANC visits, MPDSR. Conducting the reviews of maternal and neonatal deaths was a challenge. We now have the burden of also HIV. . We have the significant cases of sexual and gender-based violence. Also, additionally, …we're having challenges with matters to do with the reproductive health for especially adolescents and young people. We have a lot of adolescent pregnancies."…**KII with CHMT member***

The project targeted the basic and needs and priorities o that were informed by the high maternal and neonatal mortality burden within these six counties. The JP set out to address the needs, priorities and underlying factors contributing to high MMR and NMR. These factors included low uptake of antenatal care, low uptake of skilled deliveries, female genital mutilation and negative socio-cultural practices, and gender-based violence.

> *…..the project is very relevant to this county and its people. Considering some of our key indicators. Skilled delivery, family planning coverage, four ANC visits, MPDSR. Conducting the reviews of maternal and neonatal deaths was a challenge. We now have the burden of also HIV. . We have the significant cases of sexual and gender-based violence. Also, additionally, …we're having challenges with matters to do with the reproductive health for especially adolescents and young people. We have a lot of adolescent pregnancies."…**KII with CHMT member***

Beneficiaries

The program adequately targeted rightful beneficiaries, both direct and indirect beneficiaries. Direct beneficiaries were women (including first time mothers), children and adolescents. Indirect beneficiaries included TBAs, CHVs, S/CHMTs, health care workers and gatekeepers. Gatekeepers comprised religious leaders, administrative officers, and the male champions. This group of people have the ability to make changes and influence the health and wellbeing of women, adolescents and children. The male involvement engaged people who are in position of authority and can make changes within the community. Health service providers were targeted with capacity building to improve the quality of care on key RMNCAH areas such as BEmONC, LARC, FIC, FP among others. This UN H6 JP prioritized health service providers' training to improve the quality of care and also improve the customer care relationship between health service providers and clients. Health facilities were also beneficiaries through infrastructure improvements and equipment including building of additional maternity units and renovation of existing ones.

In Mandera County for instance, the JP Procured and distributed RMNCH equipment to all health facilities in the County, donated 1 utility vehicle to support County Health Department operations, procured 4 new ambulances to support referrals in the County, and completed Dandu community life centre (CLC).

Program response to current and emerging priorities

This evaluation established that over the past 5 years of program implementation, there has been a lot dynamism in the space of RMNCAH/HIV/GBV and the county needs kept on changing from time to time. Frequent insecurity from clan clashes and Al-shabaab posing a risk to health care providers and negating gains made in past years especially in Mandera, Wajir, Lamu and Marsabit. This in turn led to high turnover of non-local technical staff as a result of insecurity making health services interrupted. Recurrent health care providers' industrial strikes in the implementing counties also interfered with JP direct beneficiaries' access to quality services. Frequent outbreak of diseases due to porous borders and poor health systems in the neighboring countries also disrupted focused implementation of JP by shifting resources to respond to the outbreaks.

As at 27th September 2020, Kenya had confirmed a total of 37,348 COVID-19 cases with 24,253 (64.9%) having recovered and 648 (1.7%) having died. Total confirmed cases in implementing counties are as follows: Migori (350), Lamu (49), Wajir (38), Lamu (37), Mandera (28), and Marsabit (15). Since onset of COVID-19 pandemic in Kenya, it has continued to disrupt the provision of essential health services due to barriers to the supply and demand for services. On the supply side, medical personnel normally providing essential RMNCAH/HIV/GBV health services partly diverted to respond to COVID-19 and health care workers exposed to COVID-19 patients self-isolated or quarantined. In some cases, some health care workers succumbed to COVID-19 following infection. Both financial and human resources in the H6 implementing counties were shifted to respond to COVID-19 pandemic including emergency preparedness, procuring of PPEs, and hiring of additional health care providers. In addition to mortality and morbidity directly attributed to COVID-19, the pandemic posed a significant risk of disrupting provision of essential health services including RMNCAH/HIV/GBV. In the initial months of COVID-19 onset in Kenya, people utilized fewer essential health services during the

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COVID-19 pandemic due to 7pm-5am curfew and travel restrictions into and out of some counties. Some people avoided going to hospital for fear of contracting COVID-19 or being put under quarantine in case they exhibited some signs of COVID-19. To some extent, some people lost income due to curfew and travel restrictions thus limiting people's ability to pay for services and limit utilization.

Due to COVID-19, most RMNCAH indicators for January – June 2020 period in the six counties are much lower than data of the same period in the previous two years. At programme level, the JP had to re-programme activities to include sensitization of health care workers and managers on prevention-IPC and management of COVID-19 cases in the maternity and paediatric departments. In addition, some programme activities such as site visits and supportive supervision could not be implemented due to COVID-19 containment measures especially social distancing measures and travel restrictions. These COVID-19 related challenges affected the achievement of some programme targets for 2020. As a mitigation measure, the programme adopted virtual platforms to engage implementing partners and facility teams.

During annual review and planning meetings between the JP with respective county governments and/or other partners, immediate and emerging RMNCAH needs likely to affect achievement of any of the three JP outcomes areas were identified and interventions/activities with potential high impact prioritised for inclusion in the subsequent annual work plans based on available resources. Thus, this program was responsive and addressed both emerging and immediate needs of each of the program implementing counties.

4.3 Evaluation Question 2: Effectiveness and Strategic Alignment

1. To what extent did the interventions supported by the programme in all areas contribute to the achievement of planned results (outputs and objectives as stipulated in the results framework)?

2. To what extent has RMNCAH programme supported interventions contributed to the capacity development and service delivery in the 6 Counties and addressed the most pertinent needs?

3. To what extent are the H6 partners coordinated for effective delivery of the RMNCAH programme

4. To what extent are the H6 partners strategically aligned with other UN Agencies for effective UN Coherence

The ETE analysed results at outcome level, using a three pronged approach: I) assessment of performance of outcomes through review of performance trends of output and outcome indicators; ii) assessment of the performance of outputs under each outcome and how this has contributed to performance of outcomes and iii) ETE key informants' opinion based on overall perspectives around the three outcome areas.The desk review, review of the M&E data, and the qualitative data from the KIIs and FGD showed strong programme design and implementation. In examining whether the programme made sufficient progress towards its expected outcomes and to what extent (e.g. fully achieved, partially achieved, or not achieved), the achievements were independently verified through the above-mentioned methods. Detailed performance across indicators in the JP results framework is presented in annex 6. Below is description of achievement for each of the three outcome areas.

Outcome 1: Improved access to, and quality of, integrated RMNCAH, HIV, and GBV services

During phase one (2015/2016) of the programme, critical gaps in availability of requisite infrastructure and equipment that was critically hampering delivery of RMNCAH services in health facilities especially at level 2-4 was identified. Priority health facilities to be renovated/ improved and equipment gaps to be filled by the JP was agreed on with respective counties based on existing gaps. The priority infrastructure and equipment support provided included the following: (1) provision of equipment to enhance capacity of health facilities to provide quality RMNCAH services. Some of the equipment provided included delivery kits, operating theatre tables, anaesthetic machines, the theatre lamps, weighing scales, fetoscopes, delivery couches, portable ultrasound, Solar refrigerators, Solar lights, utility vehicle, ambulances, pulse oximeters, oxygen concentrators, and outreach motorbikes (2) Set up or renovate existing RMNCAH units (Maternity units, MCH unit, NBU, Maternal Shelter, and Youth Centre) to provide conducive room for RMNCAH services. collectively, tthese interventions increased Proportion of L2 to L4 health facilities that provide the entire package of BEMONC services across H6 implementing partners. For instance, in Lamu, proportion of BEmONC facilities rose from 60% to 88%; in Isiolo 54% to 59%; Mandera 38% to 60%; Marsabit 50% to 64%; and Migori 36% to 70%. The constructions and renovations enhanced the capacity of health facilities to offer quality RMNCAH services. This is firmed up by responses from key informants at county and facility level.

For instance, one CHMT member indicated:

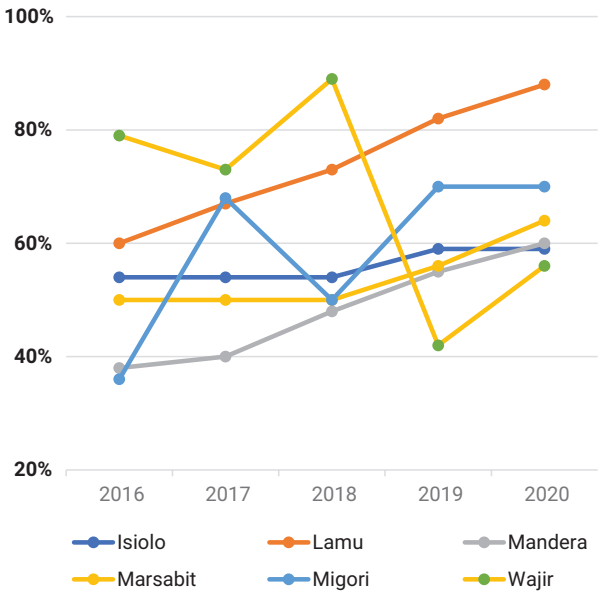
> *"….One other area I think that was very relevant and has improved service delivery is the equipment that we benefited from through this project. Both BEmONC and CEmOC equipment. I remember we received like the delivery kits for the BEmONC services. We also got operating theatre tables, anaesthetic machines, the theatre lamps for strengthening the CEmONC services in the county"*

In counties with multiple donors operating in the RMNCAH/ HIV/GBV space such as Migori County, it was difficult to identify most of the equipments supported by UN H6 JP agencies as most of them lacked branding marks.

Two maternity shelters were put up in Marsabit and Isiolo counties within existing primary health facilities to provide a suitable relief for mothers who live in far and remote areas and directly contribute to increased utilization of maternal and child health services. However, utilization of this facility, especially in Isiolo (at Kinna health center) did not translate to what was expected by the program.

It has largely remained underutilized since right from program design stage, other socio-cultural factors that could have influenced its utility were not considered beyond setting up the infrastructure. Delivery in the catchment community is largely communal and in most cases a mother would come accompanied by several relatives posing a challenge on how they can be accommodated at the facility as they await delivery. Additionally, there are other operational costs to take care of the mother as she awaits to deliver. Even though the program did not meet its targets across counties on number of BEmONC facilities, the proportion of health facilities supported by the JP to offer BEmONC services increased gradually across the years as shown in figure 4.1 below.

FIGURE 4.1. **Proportion of L2 to L4 health facilities that provide the entire package of BEMONC services**



Source: Program reports and DHIS2

The evaluation established the program conducted extensive capacity building and strengthening of Human Resources for Health across the six target counties. These targeted key personnel at county, sub-county, facility and community level. In the initial years of program implementation, nurses, clinical officers and medical officers were trained on key areas such as EmONC, IMCI (Integrated Management of Neonatal and Childhood Illness), ICCM (Integrated Community Case Management), FANC, AMSTL, KQMH, LARC, MPDSR, S/GBV, Commodities security, MCH flow chart to link facilities, and Kangaroo mother care. Through this program, mothers, children and adolescents benefited including more pre-term babies who accessed high impact interventions such as the kangaroo mother care. This has been followed up by routine mentorship to sustain gains made. This equipped the health care workers in H6 counties with requisite skills and knowledge to respond to emergencies at lower level hospitals, including improved capacity to timely diagnose and refer adequately. The JP also trained 30 County TOTs from the H6 Counties to conduct training and mentoring more Health Care Providers (HCPs), duty bearers and communities in respective counties on provision of GBV services and were tasked with cascading GBV training and mentorship within the 6 counties. Health Care Providers from 3 H6 counties (Lamu, Migori, Marsabit) were trained on prevention and response to SGBV. This led to an increased understanding on the legal and policy framework for prevention and response to GBV in the counties, provision of quality and timely medical services for survivors of SGBV and sensitization on role of Medical practitioners in the referral pathway. The program set up several community units across the six implementing counties. Community Health Volunteers have been trained in several areas such as Community Reproductive Health package, ICCM, community family planning, and increasing access to health services within the community. Over 180 CHVs were also trained to be champions on the role of men in RMNCAH and ending GBV for women and girls in the 6 counties. The trained champions utilize training manual developed by the JP and is key in enhancing local resilience towards prevention and response to Gender Based Violence Programs. The JP trained champions (men and boys) leading sessions on RMNCAH in Mandera, Migori, Wajir and Lamu and GBV through a peer to peer engagement and outreach campaigns in Marsabit and Isiolo using the training manual developed by the JP. However, this evaluation established existence of high turnovers of trained health care workers, leadership transitions and staff exit posing a challenge to sustaining program gains. Other than offering services within facilities, the JP also supported integrated medical outreaches in the community.

Strengthened referral system

In each county, the JP through supported development of County Referral Strategy and ambulance policy. The programme procured ambulances for the counties and refurbished some existing ones to basic life support and advanced life support in addition to supporting utility vehicles.

The utility vehicles largely supported support supervision activities and in some cases sample networking and transportation. In addition, strengthening of the Referral System through Expert Movement was key in supporting lower level facilities to benefit from RMNCAH experts who visit lower level facilities on specific days in a month to handle complicated cases. This resulted in an established functional county Referral system as is the case in Migori and Wajir, and improved access to health facilities during emergencies especially in Marsabit and overall contribution to reduced maternal deaths. Strengthening the referral system through sample movement also ensured wider access to laboratory services through better utilisation of available laboratory capacity in the counties.

Outcome 2: Increased demand for quality RMNCAH, HIV, and GBV services -

Demand Side Financing Initiatives

The program improved demand for RMNCAH/HIV/GBV Services through various interventions such as Procurement of Mama kits, TBA Vouchers and reorientation of TBAs to RMNCAH referral agents, and provision of transport vouchers. The JP re-oriented TBAs to be collaborators and were mainstreamed into health system thus referring clients seeking their services in their homes to facilities so that they get a safe facility delivery. TBAs were offered with training 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. This contributed to gradual improvement in SBA indicator. However, there still remains active TBAs across the six counties and coupled with cessation in the transport re-imbursement to TBAs, there is a risk of engaged TBAs reverting back to active delivery noting that a majority of them do not have alternative income generating activities.

The Introduction of the mama kits had a significant contribution in attracting mothers to facility for the 4 ANC visits and also to deliver their babies. In some cases, there were more mothers coming to facility for delivery when these kits were available as compared to when there was a stock-out of the kits. Coupled with other factors at the facility (such as quality of care) and community mobilization efforts by CHVs and TBAs in the community, more mothers attended ANC and delivered in the health facilities. This 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 as shown in figures 4.2, 4.3 and 4.5 below. Data from DHIS2 indicated that proportion of pregnant women attending at least 4 ANCs in Marsabit county increased from 37% in 2016 to 46% in July 2020. With regards to proportion of skilled birth attendants in Marsabit county, it has been increased from 46% to 76% during the same period as shown in Annex 6. Comparatively, data from other counties on proportion of pregnant women attending at least 4 ANCs vs proportion of skilled birth attendants between 2016 to July 2020 is as follows respectively: Mandera 12% to 24% vs 29% to 69%; Isiolo 85% to 73% vs 68% to 93%; Lamu 61% to 64% vs 57% to 89%; Migori 36% to 68% vs 60% to 85%; and Wajir 25% to 64% vs 45% to 45%.

FIGURE 4.2. **Proportion of women who had at least 4 ANC visits**

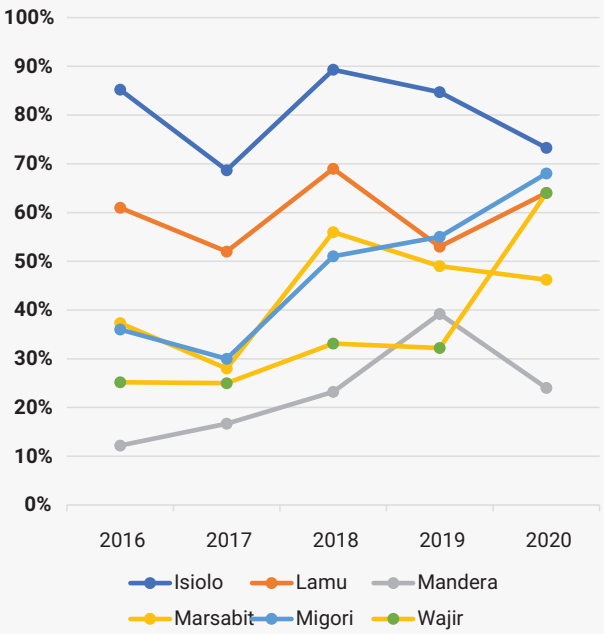
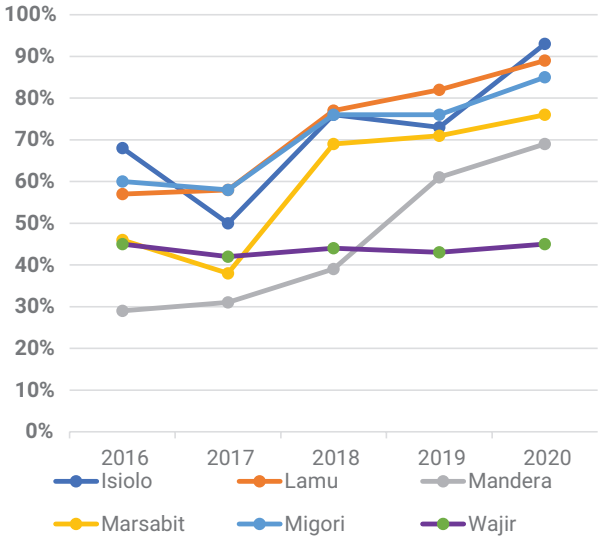


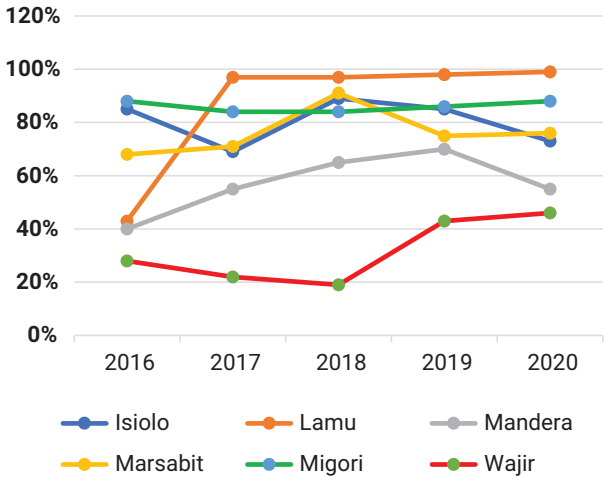
FIGURE 4.3. **Proportion of expectant mothers receiving skilled birth deliveries have consistently increased over the project life**



The mama kits have been a game changer in the six counties. The JP has been catalytic with resulting some funds from the World Bank program going down to the county being set aside by some counties to procure mama kits. Even though progress towards target achievement has been on an upward trend over the program life, only Migori County achieved its target at 85% and there still remains gaps across counties with significant numbers still delivering at home.

New ANC mothers attending ANC for the first time received HIV test with highest proportion of those tested coming from Lamu and Migori counties as shown below in figure 4.3.

FIGURE 4.4. **Proportion of ANC clients tested for HIV among new ANC client's coverage**



Source: Program reports and DHIS2

Several interventions targeting adolescents improved their utilization of adolescent friendly services at the health facilities. Notably, formation of adolescent groups brought together adolescents to freely interact and exchange ideas during these forums. In counties such as Migori, 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. Across the JP counties, the first-time young mothers' clubs formed in facilities encouraged first time mothers to interact and share information among the peers. This encouraged more uptake of ANC and facility deliveries. The young mothers felt more supported during pregnancy and birth process.

Uptake of modern FP methods among women of reproductive age increased significantly across implementation years beyond targeted numbers as indicated in table 4.1 below.

Table 4.1 Number of women of reproductive age receiving modern family planning aged 15–49 who receive modern family planning

County	Target	2016	2017	2018	2019	2020
Isiolo	4132	6188	4946	9648	9664	6906
Lamu	80%**	4539	3885	5391	5722	3354
Mandera	7519	6030	7791	18272	12689	5158
Marsabit	6538	5738	7983	19279	10318	4552
Migori	134813	151,665	124,912	153,833	151,532	119,078
Wajir	9613	8113	6,107	4,713	9,516	9,832

Dialogues/sensitization of community and religious leaders and sensitization of the public through the media

Key interventions implemented by the JP such as engagement of community, religious and other leaders through dialogue/advocacy meetings on Sexual Reproductive Health and Rights (SRH&R) including ASRH and GBV improved demand for RMNCAH/GBV services. Religious and cultural leaders, who are non-traditional partners in community level activities, were engaged to advance campaign towards eradicating GBV and promote RMNCAH. Community members are gradually being influenced to eradicate GBV and promote RMNCAH.

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In addition, Men and Boys trained leading actions and inventing ways of bringing the GBV and RMNCAH dialogues using community level mechanisms where these two issues were never discussed before.

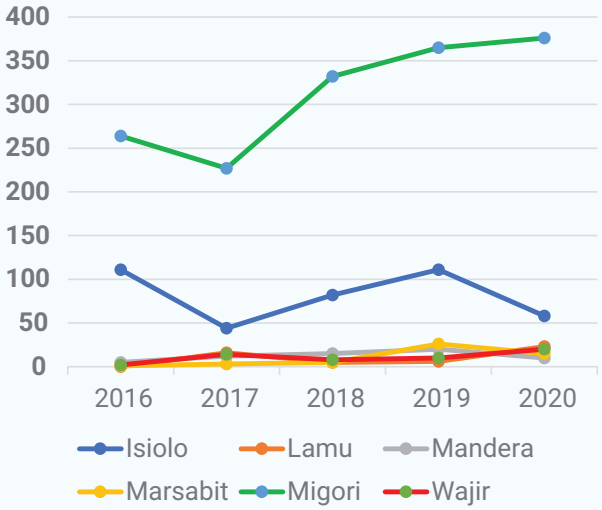
He for She campaign - Male champions

Through male champions, the program conducted community engagements and mobilized men towards changing attitudes and practices to become champions of against GBV and also promoting women's use of SRH services. Each male champion is assigned to engage 20-25 men in community dialogue.

The JP utilized innovative approaches to reach men and boys. For example, in Lamu County, the men and boys engaged designed a community outreach activity targeting men in social evenings where they were able to prepare coffee, and which brought together men and boys to discuss RMNACAH and ending GBV. The *"Kahawa Evening RMNCAH and GBV Dialogues"* involves brewing of coffee and snacks as men and boys discuss RMNCAH issues.

These efforts are geared towards ensuring GBV cases are minimized whereas those who have experienced GBV facilitated to access post GBV care since there is a very strong connection between GBV and ability to make free and informed choices on sexual reproductive health and rights. The JP capitalized on use of civil society organizations (CSOs), who are closer to the community, live within communities affected, and better understand GBV issues experienced. This provides an opportunity to CSOs to builds their own capacity in engaging on the same issues and be able to pinpoint policy gaps. UN Women contracted FEMNET which contracted other CBOs to offer GBV services. However, implementation through a third party coupled with low allocation of resources to the GBV component, visibility of GBV interventions was low in some counties. The figure 4.5 below shows GBV cases across counties over the implementation period.

FIGURE 4.5. **Number of survivors of GBV who attended health facilities where received the full package of GBV health sector services**



Consultative engagements with political leaders on RMNCAH indicators using the RMNCH Score card at ward level increased ownership and promoted prominence of RMNCAH/GBV services at community level. In addition, use of media – radio talk shows and spots contributed to increased uptake of the services.

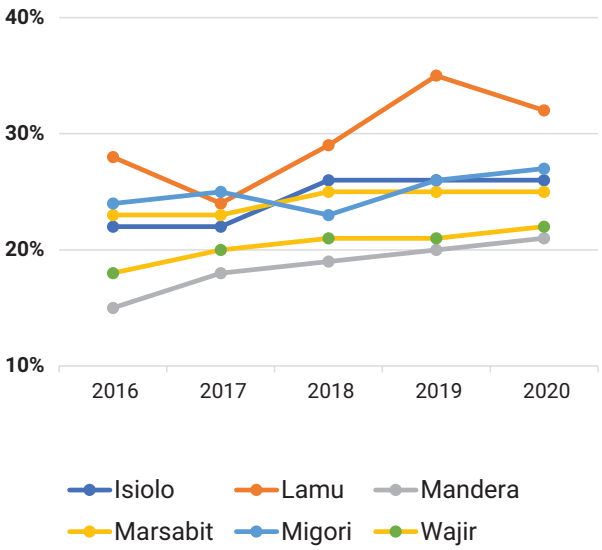
Outcome 3: Strengthened institutional capacity at county and national levels for planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services

The JP enhanced capacity of County Health Management Teams (CHMTS) in developing the county health sector strategic plans, development of policies such as GBV policy in Migori, annual work planning, CHMT supportive supervision and budgeting. Health care workers were trained on on RMNCH scorecard. In addition, training of Health Care Workers on MPDSR and holding of MPDSR Review Meetings were conducted to ensure accountability. As such, community health volunteer teams were formed and trained on Community Based Maternal Death Review. All the six counties had a functional MPDSR system that routinely used the results to influence policies and activities in the respective county. Routine data quality assessments conducted ensured continuous improvement in the quality of data.

The JP also set up a health and HIV situation room to support CHMTs in six counties closely track progress, identify indicators lagging behind and reasons for that in real time. It was envisaged it would offer an opportunity to immediately analyse the situation and go back to do improvement or make necessary implementation adjustments whether in terms of policy or program effectiveness to achieve desired level of results. Apart from setting up situation room infrastructure (screens) and iPads/Tablets in the six counties capacity building on the situation room was done for all the counties. Each county had at least the RMNCAH Coordinator, CASCO and CHRIO trained in use of the situation room platform, indicators and analyses that would help track progress or lack thereof. However, staff movements, revision of the data collection forms for DHIS, discontinuation of the iVedix platform (on which participants were trained) affected sustenance of the situation room use in the counties.

The program also printed and distributed RMNCAH/GBV data collection and reporting tools including IEC materials and job aids such as MCH booklets, KQMH, GBV, PMTCT SoPs and protocols, CHV iCCM job aids, GBV registers and GBV reporting tools, and GBV training manual.

FIGURE 4.6. **Proportion of overall county expenditure that is allocated to the health sector**



Program advocacy efforts

The program built the capacity of county leaders (through trainings, mass media and distribution of advocacy materials) to be able to advocate and see the importance of addressing maternal and neonatal burden issues in their respective counties. Members of county assembly were engaged and enlightened in forums and they agreed to support the budgeting process and this included in CIDPs. As a result of JP county level ownership and continued advocacy efforts, the overall county expenditure allocated to health sector has generally been on an upward trend over the years as shown in figure 4.5. However, only Isiolo and Lamu counties ever met their annual target with the rest falling short of the target.

The UN H6 JP collaborated with stakeholders such as NCPD on advocacy and campaign to end preventable maternal and neonatal deaths in high burden counties. This was very successfully campaigned. For instance, in 2016 the JP held a meeting that was organized by His Excellency the president of Kenya on the counties with the highest maternal and neonatal mortality where a decree was given to reduce preventable maternal death and child mortality with clear targets set for each county. This was a very successful advocacy from the highest level in the office. During the Nairobi Summit on ICPD25 held from 12 to 14 November 2019 in Kenya, the president committed the country to address RMNCAH issues and now it is being integrated in the national and the county development plans and strategies. The JP also complimented the efforts of the Beyond Zero campaign by the first lady. This was also a good advocacy opportunity utilized by the JP to advance the campaign in reducing maternal and neonatal mortality.

The program-built capacity of people living with HIV (PLHIV), CSOs and partners to be able to advocate on the need to include sexual reproductive health rights for women living with HIV in policies, programs and funding mechanisms. Two critical outcomes have been achieved through this process. The new Kenya AIDS Strategic Framework (KASF II) 2020/2021-2024/2025 has included SRHR for women living with HIV as a critical intervention area. In addition, Kenya has included strategies on SRHR for women living with HIV in its Funding Request to the Global Fund for the period 2021-2024

Overall, the successful advocacy efforts are well summed by one of the key informants:

> *"... the joint efforts I think of the partnership has resulted in that high advocacy level from the highest office in the country of Kenya. And in my opinion, this program was in terms of advocacy, was very successful in terms of you know, creating the prominence for maternal and child health".*

Monitoring and Evaluation

The UNH6 JP occasionally conducted joint monitoring Mission in collaboration with the County Health Management Teams (CHMTs) in most counties. The visits sought to monitor status of JP implementation, identify constraining factors, document lessons learnt, and resolve bottlenecks for any issues identified. Overall, there was tracking of program performance using varied outcome indicators across the three outcomes. There is varied achievement against set targets across indicators as shown in the tables above. However, the Monitoring and evaluation component was weak with some indicators not well tracked with targets, baselines and/or progress results not documented. Even though greater efforts went in utilizing data at each implementing partner level, respondents expressed inadequate continuous exchange of data/information, sharing of lessons learnt and continuous engagement especially at the national level. Key program M&E staff ought to be fully embedded in the program both at national and at implementing partner level to ensure adequate tracking of indicator performance and data utilization.

4.4 Evaluation Question 3: Efficiency

The ETE focused on the following:

1. To what extent have the H6 Partners made good use of its human, financial and technical resources to pursue the achievement of the objectives defined in the RMNCAH programme Document?

2. Were the available resources adequate to meet RMNCAH JP Needs? Was the approach used to support the county IPs efficient? Were there more efficient ways and means of delivering more and better results (outputs and outcomes) with the available inputs? Could a different approach have produced better results?

3. Did project activities overlap and duplicate other similar interventions (funded/supported by other donors?)

The ETE assessed the efficiency of the JP on RMNCAH in its implementation of planned activities as perceived by the stakeholders. However, the ETE did not quantify the financial cost and management procedures and its effect on programme implementation vis-à-vis the outputs, outcomes and the impact.

The ETE has established that the JP utilised its human, financial and technical resources efficiently to pursue the three programme outcomes in the six targeted counties. By implementing the programme activities jointly based on the technical expertise and mandate of each of the UNH6 partners, the programme utilised the resources efficiently and cut down a lot of duplication, and reduced the cost of delivering the RMNCAH, HIV and GBV interventions, and brought in the complementarity in its approach in the six counties. The programme also used a government systems approach by partnering and capacity building the respective county governments to implement the programme activities in the six burden, high burden counties. This allowed the JP to leverage on the health system and governance structures including human resource already in place as opposed to the UNH6 agencies setting up a programme implementation team in the counties which could have been expensive. As a catalytic programme, the JP efficiently demonstrated if partners work together, coordinate and align the little resources that are in the counties lagging behind on RMNCAH, and with the support from the political leadership at county and national levels, much can be achieved and there is value for money with the right investment based on actual needs.

Despites of the gains that were made by the JP, there were challenges that affected the efficiency of the programme. One was the fact that each of the UNH6 agencies implemented the programme using their own systems, and some of the efficiency gains that the programme could have had through a coherent integrated approach were lost, and there was very little left that the partners could have done at that level to address some of the challenges including delays in implementation of some interventions by some partners. In terms of planning, the difference in planning cycles between the programme and the government also posed a challenge. The government planning

cycle starts from July to June while the programme utilised the calendar planning cycle that started from January to December which posed challenges in joint annual work planning due the differences in financial years because by the time the annual work plans were being prepared, the county IPs were almost halfway into the implementation of their budgets. However, efforts were made to identify the gaps and direct resources from the JP to those areas that the counties felt that there would be a gap before their next financial year. It would have been more efficient if both the planning cycles of both the counties and the programme was synchronised.

The different approaches and modalities used by the UNH6 partners to implement the interventions was another challenge that affected efficiency of the programme. UNFPA and UNICEF used Direct Cash Transfers (DCT) while WHO, UN Women and UNAIDS used a reimbursement method or direct implementation. The evaluation findings showed that DCT was more reliable and efficient that allowed counties to implement activities in a timely manner.

The financial flow delays with the UNH6 partners and to the counties affected implementation of some activities as per the Joint Work Plans especially the activities by different UNH6 partners that were envisioned to be complimentary to each other. One UNH6 partner implemented through a third partner which according to county IPs further delayed implementation and the efficiency that was envisioned in the programme. A harmonized Cash transfers (HACT) approach would have been more efficient according to all KIIs with the county IPs. However, not all UNH6 agencies had yet adopted this approach.

In terms of adequacy of the resources, the evaluation findings shown that the needs in the targeted counties were more than the resources that the JP had. The financial resources were less than what the UNH6 had expected, and the programme faced budgetary deficits throughout its implementation as shown in table 4.2 below.

Table 4.2: Joint Programme Funding Gap for 2017–2020

Description	Amount (USD)	Percent
Total budget for the UN Joint Programme on RMNCAH	40,840,833	100%
Co-financing by H6 agencies		
UNFPA	4,294,151	30%
WHO	1,898,920	13%
UNICEF	1,248,611	9%
World Bank	5,995,667	42%
UN Women	681,600	5%
UNAIDS	289,100	2%
Total co-financing by H6 agencies	14,408,049	35%
Total contribution by DANIDA	6,042,384	15%
Subtotal committed funding	20,450,433	50%
TOTAL FUNDING GAP	**20,390,400**	**50%**

Due to the funding gap, most of the UNH6 partners did their best to supplement budgets of the interventions they were allocated. However, SGBV and HIV generally had small allocations of the JP budget and this limited the depth and the reach that could have been achieved with GBV and HIV interventions. As a model, the JP demonstrated that a similar approach can be replicated in other settings with high MMR and NMR with the resources that were available. The UNH6 together with the counties, planned based on the resources that were available but not on the needs, and was not able to implement the full program as had initially envisioned due to huge financial gap.

Avoidance of duplication and overlap of intervention in the targeted counties was as strong component of JP which capacity built the CHMT on stakeholder mapping and coordination. Each county had partners' coordination committee in place which mapped all stakeholders and coordinated their interventions within the counties thorough monthly activity planning meetings. This has greatly reduced the duplication and overlap of interventions by different stakeholders in the counties. However, there were some instances of duplication of a few interventions that had been implemented by the JP in some counties like Migori that have attracted a larger pool of stakeholders.

4.5 Evaluation Question 4: Sustainability

The ETE focused on the following:

1. To what extent have the partnerships established by RMNCAH programme promoted the national ownership of supported interventions, programmes and policies?

2. To what extent are the benefits of the programme likely to be sustained by the county government after the completion of this partnership i.e. beyond 2020?

The evaluation assessed whether the gains and achievements of the JP on RMNCAH interventions are likely to be sustained after programme support ends in December 2020. The evaluation determined that the project had plans for sustainability in the design of the programme. Most importantly, the programme used a system strengthening approach and worked with the county governments to jointly plan and implement programme interventions. It also had an elaborate plan for advocacy at county and national level. These two significant programme initiatives were clear markings of sustainability of JP on RMNCAH.

In terms of promoting national ownership of supported interventions, programmes and policies, the JP, through advocacy, changed the way the national and county leadership view RMNCAH, HIV and GBV services by providing analytical evidence and recommendations to advance RMNCAH. Through advocacy, JP also forged strategic linkages with The First Lady's Beyond Zero Campaign and high-level engagement with political leadership including the presidency. This a motivated a strong desire that was demonstrated by the Joint Communique among the 15 highest burden county governors to work towards reducing and ultimately ending maternal and new born deaths. In addition, partnership agreements with each of the six highest burden counties of Mandera, Wajir, Marsabit, Isiolo, Lamu and Migori were signed to improve RMNCAH service delivery in the six counties that were targeted by the JP. The advocacy forums that brought together leadership at from the county and national level also successfully demonstrated that national and county governments can work together and own initiatives that address county specific priority issues including RMNCAH, HIV and GBV services. This has resulted buy-in and improved investments in RMNCAH which are key indicators of ownership. Generally, there commitment national and the county is to increase budget for health and specifically for RMNCAH, which can be attributed to though not entirely to the JP efforts. This has been demonstrated also by gradual increase in the allocation of resources to Health from an average of 22 % 2015 up to 26% the current financial year. Some counties like Lamu incorporated Mama Packs in their Annual Work Plans that the county now can source and procure to sustain the gains in increasing SBA since the programme introduced the Mama Pack.

The programme has also deepened H6 partnership with ministries and made efforts to policies both at national and county level as well as building the capacity of counties to plan and budget through technical advice, training and mentorship of CHMT officials that has resulted to prioritizing RMNCAH in their development plans, and a tremendous increase in resources for procurement of equipment for reproductive and maternal health, the universal health coverage, and a lot of focus on community health. Nationally, Kenya hosted the 21st ICPD summit last year and most of the RMNCAH issues were captured with the country commitments by the president and integration of RMNCAH issues in the national and the county development plans and the strategies.

By using the Systems Approach to implement the interventions, the programme enhanced the sustainability of the gains and achievements of the programme by the county government after beyond the programme December 2020 end date. The programme built the capacity of the existing health systems and structures in the six counties through training of HCWs & CHMTs, recruitment and secondment of County Coordinators to provide embedded technical, infrastructural improvement and equipping of health facilities, establishment of referral systems and community health units. Besides, the counties have also generally improved the human resource for health through recruitment and trainings since the programme was initiated. Some of these aspects of the health system are inherently sustainable and will continue to provide the RMNCAH services after the JP. For example, the JP trained some HCWs and managers to be Trainer of Trainers (ToT) on various aspects of RMNCAH and continue to train other HCW through the mentorship programme that was initiated by the JP. This will ensure that the knowledge and the technical expertise will still exist in the counties and can be used scale it up capacity building component after the JP exit due to the high staff attrition especially in the ASAL counties. For example, in Migori, a GBV ToT that was trained managed to build capacity of others by going around the county encouraging and influencing change including from CHMT to not only enhance reporting and recording of GBV but also ensure that proper services are offered to survivors.

The JP also progressively engaged and worked with cultural and religious leaders, People living with HIV, TBAs, CHVs and male champions in the six counties to be agents of change and reach out to other community members to drive the demand for the uptake for RMNCAH, HIV and GBV services. For example, some counties have incorporated of TBAs in the health system through incentives to refer and/or escort mothers in labour to health facilities while others have been absorbed them as CHVs and in Mother to mother support groups which were initiatives of the JP as a strategy to increase SBA, and male engagement forums to enhance GBV protection mechanisms.

To ensure sustainability, some counties have brought on board others partners to stepped in to support some JP interventions activities e.g. USAID funded project that is now also supporting the Toll-free number in Migori, ADS and World Vision in Isiolo which is now family planning, Safaricom Foundation through Access Kenya Program is supporting the mama packs among others. Nationally, the Global Fund and PEPFAR funding will support HIV interventions including in the 6 targeted counties. The government is also committed to roll out the UHC across the 47 counties which if implemented can also sustain the initiatives that were started through the JP.

Despites of the hallmarks of sustainability of the JP gains, the UNH6 did not have a clear exit strategy. At programmes level, there was a need for a framework that clearly defines the exit plans and strategy with changed roles for sustenance of programmatic gains beyond the end of the programme in December 2020. As much as the JP did not have a clear exit strategy, individual H6 partners indicated a commitment to continue resource mobilising and support the intervention they implemented in the six counties. For example, UNFPA and WHO indicated that they will continue to provide technical assistance while UNICEF will continue supporting the evidence generation, drafting of the CIDPs and high impact interventions beyond the RMNCAH program by through other programmes they are supporting in the six counties.

4.6 Evaluation Question 5: Coordination & Partnership

The ETE focused on the following:

1. What are the main comparative strengths of H6 Partners in Kenya and how are these perceived by the national, County and international stakeholders?
2. To what extent are the H6 Partners coordinated in implementation of the RMNCAH programme, including adherence to the Implementation Framework?
3. To what extent are the H6 partners coordinated with other UN agencies to Deliver as One, particularly in the areas of potential overlap?

The JP Programme *as UNDAF Flagship initiative* on RMNCAH provided a good opportunity for the agencies to demonstrate how UN can Deliver as One (DaO). The agencies leveraged on their different comparative advantages to implement the programme activities in complex and dynamic environments in the six targeted counties. The UNH6 partners under the leadership of UNFPA as the administrative agency put in place measures such as joint annual planning, reviews and monitoring visits to ensure coordination in planning and implementation of the programme among the partners and the counties. The programme having county coordinators to work within the county government system at CHMT level also enhanced the coordination and understanding of the programme at county level. At UNH6 level, the Heads of agencies Secretariat and the Technical teams meeting regularly to review programme implementation also enhanced coordination and DaO, and promoted strong level of interaction, coordination and collective buy-in at the highest levels of UNH6 agencies. This was evident in the second half of implementation after the mid-term review through which initial challenges in terms of coordination were identified and addressed.

In terms of implementation, there were coordination challenges as a result of each UN agency approaching the counties in their own ways and using their own systems which were not exactly uniform and the JP at the country level didn't have control over it yet there was a need to further integrate and align their systems. The result was that while the agencies had a coherence of vision, result and strategy, they "scattered" in their different directions and processes in implementation of JP interventions which resulted in loss in some level of coordination, synergy and efficiency, and silo interventions at the county level in some instances. It also resulted in difference in perception of the H6 partners by counties in terms of their responsiveness and execution of the programme activities. The sub-optimal coordination in implementation also affected the adherence to the joint work plans especially the agreed timelines of the JP interventions. As much as the coordination strengthened the partnership between the JP and county health departments, there was a gap in engaging the national MOH which only happened towards the end of the program.

For JPs to be successful, there should be concerted efforts in coordination of proactive resource mobilization through documentation and dissemination of the programme achievements to mitigate the challenges that were experiences as a result of budgetary deficits. The UNH6 programme on RMNCAH was not able to communicate in a more coherent and strategic manner the results that it had been able to deliver in the six high MMR counties, and demonstrate to its gains to donors and governments more significantly. However, at the time of the ETE, there were plans to share results, good practices and lessons learnt, and how the programme can be scaled up in the same counties and/or beyond on donor platforms.

Despite of various challenges, the DaO approach has been overall successful and UNFPA has played a constructive role in coordinating all UNH6 agencies towards delivering as one considering the dynamic political, policy and security environment in which the programme was which required optimum coordination at all levels between agencies to get DaO "right". The comparative advantages for the JP were the complementarity of the technical support that they provided, their potential to jointly fundraise and combined ability to undertake advocacy at the county, national and global levels. As a flagship programme, it provided an opportunity for UN agencies to learn and make improvements moving forward.

4.7 Innovations and creative strategies

Reaching men to advance RMNACAH services and ending GBV

The programme has devised innovative approaches to reach men and boys. For example, in Lamu County, the men and boys engaged designed a community outreach activity targeting men in social evenings where they were able to prepare coffee, and which brought together men and boys to discuss RMNACAH and ending GBV. The *"Kahawa Evening RMNCAH and GBV Dialogues"* involves brewing of coffee and snacks as men and boys discuss RMNCAH issues. This space was previously focusing on the issues around politics and sports, but the trained champions succeeded in promoting male involvement in RMNCAH and ending GBV as a main topical issue. These self-created spaces have potential of reaching men and boys away from the mainstream programming or planned activities in the project. These community spaces sustain engagement of men and boys and the community at very minimal cost and are already in use in the communities. Reports are the summarized and shared.

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Chapter
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Conclusions

5.1 Strategic level

Conclusion 1: The UNH6 JP was relevant and strategically aligned to international development goals (SDGs 3 and SDG 5), UNDAF outcome on Human Capital Development, county and country priorities as contained in Kenya's vision 2030, Medium Term Plans, strategic plans, and the specific needs of target direct and indirect beneficiaries. However, only 6 of the 15 high burden counties benefited from the program.

The UN H6 JP was relevant to the needs of target direct and indirect beneficiaries, Kenya's strategic plans, county priorities, UNDAF outcomes, and SDGs 3 and SDG 5. It specifically contributes towards the UN Secretary-General's, *Every Woman Every Child* global strategy towards keeping women's, children's and adolescents' health and wellbeing at the heart of development. Critical top line indicators for SDG 3 and 5 on maternal mortality, child and new-born health were directly responded to. In addition, the JP was aligned to Kenya's Vision 2030, the Medium-Term Plan, and the RMNCAH investment framework. The programme was also a direct response to the gaps and needs in the six most affected counties lagging. The program targeted 6 of the 15 high burden counties, and adequately targeted rightful beneficiaries, both direct and indirect beneficiaries.

Based on EQ 1, Evaluation criteria: Relevance

Conclusion 2: The JP Programme as UNDAF Flagship initiative has demonstrated that UNH6 agencies can Deliver as One (DaO) with adequate planning and consultations. However, UN agencies need to harmonise approaches and work more closely to achieve coherence and uniformity in implementation of joint programmes.

The agencies leveraged on their different comparative advantages to implement the programme activities in complex and dynamic environments in the six targeted counties. Overall, the DaO approach was successful and UNFPA has played a constructive role in coordinating all UNH6 agencies towards delivering as one considering the dynamic political, policy and security environment. However, the programme delayed in bringing on board the participation of the H6 Head of agencies as members of the steering committee which could have assisted in resolving the issues in the inception phase if there was active engagement and involvement of all the heads of agencies right from the beginning.

Based on EQ 2, 5, Evaluation criteria: Effectiveness, Coordination, and partnership

Conclusion 3: The UN H6 program greatly succeeded in holding advocacy campaigns to create prominence for RMNCAH/HIV/GBV services to end preventable maternal and neonatal deaths in high burden counties. This was because of sustained advocacy efforts throughout program implementation at national and county level.

The program built the capacity of political and health officials leaders (through trainings, mass media and distribution of advocacy materials) to be able to advocate and see the importance of addressing maternal and neonatal burden issues in their respective counties. As a result of programme ownership and continued advocacy efforts, the overall county expenditure allocated to health sector has generally been on an upward trend over the years. The UN H6 JP collaborated with stakeholders such as NCPD on advocacy and campaign to end preventable maternal and neonatal deaths in high burden counties, incorporation of SRHR for women living with HIV as well as GBV in policies, plans and funding mechanisms at national and county levels.

Based on EQ 2, 5, Evaluation criteria: Effectiveness, Coordination, and partnership

5.2 Programmatic level

Conclusion 1: The UN H6 contributed significantly towards improving access to, and quality of, integrated RMNCAH, HIV, and GBV services through provision of RMNCAH equipment, capacity building and strengthening referral system. However, high turnovers of trained health care workers, leadership transitions and staff exits posed a challenge to sustaining program gains.

The programme addressed critical gaps RMNCAH infrastructure and equipment that were affecting delivery of RMNCAH services in health facilities especially at Level 2-4 by improving infrastructure and providing equipment. The programme also supported extensive training and mentoring of HCWs across the six target counties on key RMNCAH areas which equipped the health care workers with requisite skills and knowledge to respond to emergencies at lower level hospitals, and also be able to diagnose in time and refer adequately. However, high staff attrition threatened the sustainability of the gains and achievements of the JP programme including as identifying the equipment that were provide by the programme in counties such as Migori that have many stakeholders in the RMNCAH space.

Based on EQ 2, 3, 4, Evaluation criteria: Effectiveness, Efficiency and Sustainability

Conclusion 2: The UN H6 JP contributed significantly towards increasing demand for quality RMNCAH, HIV, and GBV services through utilization of Mama kits, TBA vouchers and reorientation of TBAs to RMNCAH referral agents, transport vouchers and use of male champions. However, there still remains active TBAs across the six counties and coupled with cessation in the transport re-imbursement to TBAs, and there is a risk of engaged TBAs reverting back to active delivery noting that a majority of them do not have alternative income generating activities.

The program re-oriented TBAs to be collaborators with health facilities in efforts to mainstream them into health system to refer clients seeking their services in their homes to facilities so that they get a safe facility delivery. They were offered with training 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. There is evidence across the six counties of this working and as also evidenced by gradual improvement in SBA indicator. The Introduction of the mama kits that UNICEF supported, had a significant contribution in attracting mothers coming to facility for the 4 ANC visits and to deliver their babies. Coupled with other factors at the facility (such as quality of care) and community mobilization efforts by CHVs and TBAs in the community, more mothers attended ANC and delivered in the health facilities.

Based on EQ 2, 3, 4, Evaluation criteria: Effectiveness, Efficiency and Sustainability

Conclusion 3: The program contributed significantly to strengthening institutional capacity at the six counties towards planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services. However, the Monitoring and evaluation component was weak especially on sharing of data/information and lessons learnt at the national level. Some indicators were not well tracked with targets, baselines and/or progress results not/inadequately documented.

Even though greater efforts went in utilizing data at each implementing partner level, respondents expressed inadequate continuous exchange of data/information, sharing of lessons learnt and continuous engagement especially at the national level. Key program M&E staff ought to be fully embedded in the program both at national and at implementing partner level to ensure adequate tracking of indicator performance and data utilization.

Based on EQ 2, 3, Evaluation criteria: Effectiveness and Efficiency

Conclusion 4: The Systems approach used by the UNH6 JP on RMNCAH, HIV and GBV was efficient in utilising the human, financial and technical resources to pursue the programme outcomes in the six targeted counties. However, different approaches used by H6 partners to implement the interventions posed challenges that threatened the complementarity and synergy of interventions

The programme was implemented jointly using a government systems approach based on the technical expertise and mandate of each of the UNH6 partners which allowed it to utilise the resources efficiently and cut down a lot of duplication, and reduced the cost of delivering the RMNCAH, HIV and GBV interventions in addition to bringing in the complementarity in its approach in the six counties. The approach also allowed the JP to leverage on the health system and governance structures including human resource already in

place. However, the different modalities used by the H6 partners to implement activities caused delays that threatened the complementarity and the synergy that had been envisioned by the UNH6 agencies.

Based on EQ 2, 3: Evaluation criteria: Effectiveness and Efficiency

Conclusion 5: Most of programme interventions are inherently sustainable and are likely to be sustained by the counties despite the JP having weak and underdeveloped exit plans and strategies.

The JP worked with counties to jointly plan and implement programme interventions which resulted in enhanced capacity of the existing health systems and structures in the six counties through training of HCWs & CHMTs, embedded technical advice through County Coordinators, infrastructural improvement and equipping of health facilities, establishment of referral systems and community health units. Most of these interventions are inherently sustainable and will continue beyond the programme. Through advocacy, the JP also promoted national and county ownership of supported interventions, programmes, policies, and community led interventions. However, the UNH6 had weak and underdeveloped exit plans and strategies that does not define the exit framework with changed roles for sustenance of programmatic gains beyond the end of the programme in December 2020.

Based on EQ 4: Evaluation criteria: Sustainability

Conclusion 6: The JP was coordinated in joint planning and reviews with the counties but faced challenges in implementation because of the H6 partners using their different systems and approaches to implement interventions.

The JP put in place measures such as joint annual planning, reviews, and monitoring visits to enhance coordination in planning and implementation of the programme among the partners and the counties. However, each UNH6 partner approached the counties in their own ways and using their own systems which were not exactly uniform and the JP at the country level didn't have control over it yet there was a need to further integrate and align their systems. The result was that while the agencies had a coherence of vision, result and strategy, they "scattered" in their different directions and processes in implementation of JP interventions which resulted in loss in some level of coordination, synergy and efficiency, and silo interventions at the county level in some instances.

Based on EQ 5: Evaluation criteria: Coordination and partnership

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Chapter
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Recommendations

6.1 Strategic Level

Recommendation 1: **MOH, counties and H6 need to strengthen their strategic partnerships and mobilize more resources to optimize contribution to RMNCAH/HIV/GBV and sustain gains in high burden counties significantly contributing to high maternal and neonatal mortality burden.**

The JP was a collective action of the H6 which has demonstrated that UN agencies can effectively work together to deliver high impact interventions. As a catalytic and pilot programme, efforts should be made to jointly move from piloting to full scale implementation of the programme as initially designed. Most of the initiatives had been started, but to get the impact, there is need to scale up the programme. The H6 collaboration is still important and critical for the health sector in the six counties and the country in general, and agencies should work together to engage donors and mobilise resources at country level for sustained investment in RMNCAH/HIV/GBV and subsequent joint programme (s).

Priority level: High; Based on strategic conclusion 1

Recommendation 2: For enhanced efficiency of JP implementation, H6 agencies should harmonize approaches, work more closely, and explore alternative funds flow modalities to enhance coherence and efficiencies

Even though the JP participating agencies' business systems are distinct for each agency and each is obliged to utilize the existing respective corporate business systems, an alignment of these business systems/processes may achieve increased efficiencies and optimize overall achievement of similar initiatives. The UN H6 partners should explore alternative funds flow modalities for joint programmes to enhance coherence and increase efficiencies.

Priority level: Medium; Based on strategic conclusion 2

Recommendation 3: Future programmes should incorporate advocacy and stakeholder engagement at design stage and sustain throughout programme cycle.

The JP was successful in advocating for RMNCAH at community, county and national levels but the momentum was lost during the programme implementation due to inadequate resources that were needed for sustained targeted advocacy and continuous update of capacities and advocacy materials especially due to frequent changes in leadership at county governments which necessitated routine sensitisation of new leaders on RMNCAH, HIV and GBV programmes. Adequate resources should be allocated for sustained targeted advocacy and continuous update of capacities and advocacy materials for different stakeholders especially due to frequent changes in leadership at county governments.

Priority level: Low; Based on strategic conclusion 3

6.2 Programme Level

Recommendation 1: Counties should scale up innovative and sustainable approaches to capacity building of HCWs and leadership to mitigate high turnovers of trained health care workers and leadership transitions that pose a challenge to sustaining program gains.

The programme supported extensive training and mentoring of HCWs across the six target counties on key RMNCAH areas which equipped the health care workers with requisite skills and knowledge to respond to emergencies at lower level hospitals, and also be able to diagnose in time and refer adequately. However, high staff attrition threatened the sustainability of the gains and achievements of the programme. There is need to have innovative and sustainable measures in place to address this. Counties need ongoing investment in capacity building due to high turnovers, leadership transitions and staff exits.

Priority level: Medium; Based on Programmatic conclusion 2

Recommendation 2: Counties should consider supporting TBAs to have alternative income generating activities as a sustainability measure to deter them from reverting into active TBAs whenever incentives are not available.

The programme re-oriented TBAs to be collaborators with health facilities in efforts to mainstream them into health system to refer clients seeking their services in their homes to facilities so that they get a safe facility delivery. They were offered with training on various RMNCAH areas including danger signs in pregnancy in addition to transport re-imbursement of Kshs. 500 for every referral of a mother in labour. These incentives need to be continued to sustain gains made so far in improving skilled facility deliveries across implementing counties.

Priority level: High; Based on Programmatic conclusion 4

Recommendation 3: The UNH6 partners and counties should strengthen the learning and knowledge management strategy of joint programmes, including the generation and routine dissemination of evidence-based documentation especially achievements throughout programme cycle

The Monitoring, Evaluation and Learning component of the programme had inadequate resources especially human resources, and the affected the documentation and dissemination programme achievements. The M & E of programme as complex as JP on RMNCAH, HIV and GBV services in six counties should been anticipated during the design phase and adequate resources especially a dedicated M&E officer to support in documenting of good practices, experience and lessons routinely in a much more comprehensive manner than what was being captured by the progress report that the implementing counties were sharing. This would have enabled the programme and the counties to communicate the results in a coherent manner as well as enhancing cross-county learning and engagement with donors.

Priority level: Medium; Based on Programmatic conclusion 5

Recommendation 4: H6 agencies should have a harmonised approach when implementing joint programmes to avoid delays that threatens the complementarity and the synergy of interventions

The different modalities especially financial flow systems that were used by the H6 partners during implementation of programme interventions caused delays that threatened the complementarity and the synergy that had been envisioned by the UNH6 agencies. There is utmost need to harmonise systems of participating agencies when implementing joint programmes to enhance coherence in approach and implementation. There is need to change rigidity of H6 internal processes and systems. The agencies ought to speak to each other to the extent that people can then collectively implement as jointly and using uniform systems so that counties can follow in a more efficient manner.

Priority level: Medium; Based on Programmatic conclusion 6

Recommendation 5: MOH, counties and H6 partners should harness multi-stakeholder-partnerships including Private-Public Partnerships to mobilise more resources to address critical gaps in RMNCAH while advocating for increased domestic resources to sustain gains of RMNCAH interventions based on a clear exit strategy.

The JP faced financial gap of about 50% of anticipated funding. While most of the H6 partners supplemented budgets of their interventions, the programme still faced financial challenges. To fill the budgetary deficit coupled with reducing donor funding in Kenya since it was reclassified as a low middle income country, the H6 should have harnessed more multi-stakeholder partnerships to unlock more financing from the private sector including domestically. The JP should also have had a clear exit strategy that defines that changed roles of the H6 and counties beyond the programme to further enhance the sustainability of the gains made.

Priority level: High; Based on Programmatic conclusion 7

Recommendation 6: H6 partners and counties should strengthen coordination in implementation among agencies beyond joint planning and reviews of programmes. Approaches to strengthen complementarity at activity level should be promoted and H6 partners should approach both the county and the national level jointly during implementation ensuring adherence to joint implementation frameworks while building complementarity and synergy of programme interventions.

The JP was coordinated in joint planning and review alongside implementing county governments. However, during implementation each H6 partners approached counties using their own systems instead of a coordinated and synergetic approach at both at the county and the national level as had been envisioned when designing the programme. The administrative agency should ensure continuous engagement and sharing of information among UNH6 partners beyond joint planning and reviews to ensure adherence to joint implementation frameworks and coherence in engaging counties to harness the complementarity and synergy of programme interventions. For any future programmes, the coordination mechanisms in planning and implementation should be improved through sharing of information among the H6 partners, arms of the government and institutions.

Priority level: Medium; Based on Programmatic conclusion 8

6.3 Key Lessons Learned

Building capacity of health workers with varied technical expertise including having ToTs and sustaining them within counties and building capacities of communities and having less reliance on the national level is very essential. This reduces reliance on national expertise and ensures continued provision of services even in pandemics like COVID-19.

Flexibility in the design of a program is critical when implementing programmes in dynamic and varied county contexts in addition to addressing emerging issues and needs.

Partnerships with key stakeholders (such as government, UN agencies, development partners, the private sector, CSOs and community) helps to leverage on existing financial resources and technical expertise of various institutions to successfully mobilise resources, successfully implement and influence government.

Conducting a baseline assessment to identify needs and disparities in maternal, neonatal and child mortality burden before designing of any programme is very critical. This provides essential information to guide prioritization of fewer counties but with the highest contribution to high maternal mortality.

Reorientation and giving incentives to TBAs who are impediment to health facility visits and male involvement through community structure and creative strategies such as "Kahawa sessions" results in increased utilization of RMNCAH, HIV and GBV services.

Integration is key to delivery of successful RMNCAH/HIV and GBV program and any other program that utilizes that approach, especially with limited resources a lot can be achieved.

Demand side interventions such as the transport vouchers, Mama kits and TBA vouchers are effective in demand stimulation where socio-cultural barriers are rampant and contribute to increased uptake of key RMNCAH services.

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Chapter
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Annexes

Annex 1: Terms of Reference

Title	CONSULTANCY TO UNDERTAKE EVALUATION OF THE UN H6 JOINT PROGRAMME REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH (RMNCAH) 2015-2020
Hiring office	UNFPA Kenya Country Office
Background	Improving Maternal, Newborn and Child health is a key global agenda and is a priority for the Government of Kenya as is reflected in its Vision 2030, the Constitution of Kenya 2010 and the Health Sector Strategic and Investment Plan 2014-18. The maternal mortality ratio remains high at 362, a decrease from 488 deaths per 100,000 live births, according to the Kenya Demographic and Health Survey of 2014 and 2008/2009. This national MMR estimate however, obscures the disparities at county level. UNFPA in conjunction with University of Nairobi, Population Studies and Research Institute (PSRI) carried out a rapid situational analysis based on 2009 Population and Housing Census on the burden of maternal mortality and its distribution. This analysis showed MMR values ranging from 187 maternal deaths per 100,000 live births in Elgeyo Marakwet County to 3,795/100,000 live births in Mandera County. The study ranked all the 47 counties based on their estimated maternal mortality ratio (MMR) and 15 Counties were noted to contribute about 98% of maternal deaths. The 10 highest MMR burden counties are Mandera, Wajir, Turkana, Marsabit, Isiolo, Siaya, Lamu, Migori, Garissa and Taita Taveta. Kenya was a recipient of the RMNCH Trust Fund grant of US$ 14.9 million in support of prioritized activities to address bottlenecks and gaps on reducing preventable maternal and newborn deaths in the six high maternal mortality burden counties of Mandera, Wajir, Marsabit, Isiolo, Lamu and Migori. The funding was channeled through UNFPA, UNICEF and WHO and the activities were implemented between July 2015 and December 2016 by the County Departments of Health, Liverpool School of Tropical Medicine (LSTM), National Council for Population and Development (NCPD), the Kenya Red Cross (KRCS) and Amref Health Africa.

	In March 2016, six UN agencies (UNFPA, WHO, UN Women, UNICEF, UNAIDS and World Bank) organized themselves in a UN H6 partnership to operationalize and intensify efforts to implement the UN Secretary General's Global Strategy for Women's and Children's Health. As the funding from the RMNCH Trust Fund ended in 2016, the UN H6 agencies joined forces and secured funding from the Embassy of Denmark (Danida) to implement a second phase of the UN Joint Programme on RMNCAH (2017-2020). Leveraging on successes from the first phase, the UN H6 partners in the current second phase continued to support the reduction of maternal and newborn mortality in the six high burdened counties in Kenya. **Joint Programme RMNCAH Objectives** The RMNCAH Project was designed with the overall goal being to contribute to the reduction of maternal and newborn morbidity and mortality in the six high burdened counties by increasing utilization of integrated, quality reproductive, maternal, newborn, child and adolescent health, HIV and gender-based violence (GBV) services. The project supported activities aimed at operationalizing three core strategies namely: - 1. Scale up access and improving quality of integrated RMNCAH, HIV and GBV services (e.g. renovations, trainings in BEmONC, introducing maternal waiting homes, procurement of commodities and equipment). 2. Generate community demand for uptake of life saving reproductive health, HIV and GBV services (e.g. introducing transport and TBA vouchers and other demand side financing initiatives, work with religious and other leaders and robust community health strategy. 3. Strengthen institutional capacity at county level (e.g. providing embedded technical assistance, enhancing coordination, developing core strategic planning documents, improving health information systems, and integrating continuous quality improvement into support supervision through the Kenya Quality Model for Health to target human performance factors). **End Term Evaluation** This programme evaluation is envisaged as an in-depth analysis to assess progress made in achieving planned results, including efficiency in the utilization of resources. The report will also be used to account to donors and other involved stakeholders. The primary target group of the evaluation report are the UN H6 partners, the Government of Kenya, Development Partners and the Implementing Partners. Findings from the evaluation will be disseminated to these audiences at a report validation and results dissemination workshop as well as other platforms such as social media and websites/ portals. Therefore, UNFPA Kenya Country Office, on behalf of the UN H6 partners is seeking **for two consultants** (to work as a team) to conduct RMNCAH Project review in six counties ie. Mandera, Wajir, Marsabit, Isiolo, Lamu and Migori.
Objective of the consultancy:	The objectives of the review are: **1. Relevance:** - To assess the relevance and contribution of the RMNCAH programme to the national and county plans e.g. Kenya Health Sector Strategic Plan (2013-2017), County Health Strategic Plans. **2. Effectiveness:** - To assess the extent to which the programme implementation successfully achieved the stated objectives, including establishing how Implementation framework enabled or hindered achievements of the results chain i.e. what worked well and what did not work well. **3. Efficiency:** - To assess the extent to which the programme objectives have been achieved, with the appropriate amount of resources (funds, expertise, time, administrative costs, etc) **4. Sustainability:** - To assess the continuation of benefits after its termination, linked, in particular, to their continued resilience to risks. **5. Coordination:** - To assess the coordination of the Programme implementation among UN H6 partners and the programme counties. 6. To generate a set of clear forward looking and actionable recommendations logically linked to the findings and conclusions. These recommendations will include specific guidance on the designing of future support to strengthening counties' capacity on RMNCAH.

Scope of the review, Description of services, activities or outputs:	The RMNCAH End Term evaluation will cover interventions carried out during the programme period (2015-2020). The evaluation will cover all of the following counties where the programme was implemented: Migori, Isiolo, Wajir, Marsabit, Lamu and Mandera. The evaluation should assess all three programme objectives and the impact of the programme on the county capacity to sustain the interventions and results gained. The evaluation will cover the technical aspects of the programme as well programme management and the crosscutting aspects such coordination, monitoring and evaluation and partnerships. **RMNCAH Project Evaluation Questions** 1. To what extent is the RMNCAH programme adapted to national and county needs and policies? 2. To what extent did the interventions supported by the programme in all areas contribute to the achievement of planned results (objectives)? 3. To what extent have the H6 Partners made good use of its human, financial and technical resources to pursue the achievement of the objectives defined in the RMNCAH programme Document? 4. To what extent has RMNCAH programme supported interventions contributed to the capacity development and service delivery in the 6 Counties and addressed the most pertinent needs? 5. What are the main comparative strengths of H6 Partners in Kenya and how are these perceived by the national, County and international stakeholders? 6. To what extent are the H6 Partners coordinated in implementation of the RMNCAH programme, including adherence to the Implementation Framework. 7. To what extent have the partnerships established by RMNCAH programme promoted the national ownership of supported interventions, programmes and policies? 8. Any other pertinent questions (proposed by consultants) **Approach and Methodology** The review will adopt an inclusive and participatory approach, involving a broad range of partners and stakeholders at both national and county levels. The stakeholders may include representatives from the government, civil society organizations, the private-sector, UNFPA, WHO, UNICEF, UNAIDS, UN Women, World Bank, other bilateral donors and most importantly, the beneficiaries of the programme. During the inception stage, the consultants will conduct a comprehensive desk review to define the review design, including data collection and analysis methods and required tools. The proposed methodology is to be outlined in the inception Report prepared by the consultants with inputs from the RMNCAH Technical working group.
	Main tasks and Responsibilities 1. Develop and present a detailed inception report outlining brief preliminary desk review, data collection tools and methodology, work plan and budget. 2. Conduct desk review and analyze the programme documents including but not limited to: programme proposal, Implementation Plan and Framework, reports, national health sector plan, RMNCAH Framework, respective county health sector strategic plans and annual work plans. 3. Conduct key informant interviews with national stakeholders e.g. the Ministry of Health as shall be guided by the UN H6 Technical team. 4. Make field visits to all the six counties to evaluate programme implementations: a. Conduct Key informant interviews stakeholders in the respective counties. b. Conduct focus group discussions with beneficiaries (community level) in the selected counties.

	5. While addressing the above, the consultants will be required to review/assess the following questions: a) Analysis of the relevance of the programme in relation to the national health sector priorities – to what extent did the objectives of the programme contribute to the national health sector strategic plans? b) Analysis of the achievements of the programme in relation to the expected results c) Analysis of the performance and efficiency of programme in terms of utilization of funds vis –a –vis achieved results – the extent to which costs of the activities can be justified by the results d) Analysis and possible synergies with other RMNCAH initiatives and funds such as the Global Financing Facility and the World Bank Transforming Health Systems e) Determine the efficiency of the process of execution and the working relationships of the UN H6 partners in the programme. f) The prospects of sustainability of results achieved in service delivery and HSS, including the catalytic nature of the project. g) The added value of the RMNCAH Initiative and the lessons learned. h) Recommendations for future support to the target counties to strengthen their capacity on RMNCAH in alignment to national policies and strategies such as the Kenya Health Sector Strategic Plan, the Universal Health Coverage strategy and the Primary Health Care strategy. Make presentations and facilitate during a report validation and results dissemination meeting with representatives from the UN H6 and implementing partners.
Duration and working schedule:	1 July, 2020 to 30 September, 2020
Place where services are to be delivered:	Nairobi and Six project counties (Mandera, Wajir, Marsabit, Migori, Lamu and Isiolo). NB: Travel to Mandera and Lamu will be subject to prevailing security situation.
Delivery dates and how work will be delivered (e.g. electronic, hard copy etc.)	The team of consultants will produce the following deliverables: • A Design report that includes an evaluation matrix for the RMNCAH programme evaluation • Draft zero report after field phase which captures preliminary findings. • A debriefing presentation document (Power Point) synthesizing the main preliminary findings, conclusions and recommendations of the review, to be presented and discussed with the UN H6 partners, MOH and other partners during the foreseen at the end of the field phase; • Draft report to be presented at a report validation meeting. • A final review report, both narrative and in power point format for dissemination in acceptable quality. • **Special notes:** • The assignment will commence no later than July, 2020. • The consultants are expected to visit the six project field sites and the offices of other implementing partners during the period August, 2020. • A draft report shall be submitted to UNFPA KCO no later than 8 September, 2020. • The final report shall be submitted to UNFPA no later than 30 September, 2020. • The final report should not exceed 30 pages and include an executive summary of maximum 3 pages including recommendations for strategic direction as well as appendices. The executive summary should be readable as a standalone document.

	Roles and Responsibilities of the consultants (A team of two required) • **A Lead consultant** with overall responsibility for the production of the draft and final reports. S/he will coordinate the work of the team and will also be responsible for the quality assurance of all deliverables. The lead consultant should have a good knowledge of Kenya's national development context and be fluent in English and Kiswahili. At the synthesis phase, she/he will be responsible for putting together the first comprehensive draft of the report, based on inputs from the SRH expert. • **A sexual and reproductive health expert** will provide expertise in sexual, reproductive and maternal health and adolescent health. Besides her/his technical expertise, the sexual and reproductive health expert should have a good knowledge of the national development context and the devolved system of governance and be fluent in English and Kiswahili. She/he will take part in the data collection and analysis work during the design and field phases. She/he will be responsible for drafting key parts of the design report and of the final report.
Monitoring and progress control	Weekly email and/or calls with UNFPA M&E Specialist and programme Coordinator to discuss progress share work drafts and reports and take decisions on the way forward.
Supervisory arrangements	The successful candidates will administratively be under the overall supervision of the UNFPA KCO M&E Specialist but will report directly to, and work collaboratively with the RMNCAH Senior programme Coordinator for the assignment
Expected travels	Travels to all six programme Counties and other Implementing partner offices within Nairobi. **NB:** Travel to Mandera and Lamu will be subject to prevailing security situation.
Required expertise, qualifications and competence, including language requirements:	**Lead Consultant** • An advanced degree in either Public Health, Social Sciences, Population studies, Statistics or Demography. • 10 years' experience in conducting evaluations in the field of health, sexual reproductive health and rights including for UN agencies and/or other international organizations; • Experience in working with the national and devolved system of government. • Excellent data analysis skills in qualitative and quantitative methods. • Excellent reporting writing skills. • Ability to work in a team. **Sexual and Reproductive Health expert** • An advanced degree in either Medicine, Health Economics, Epidemiology or Biostatistics. • Specialization in public health; • 7 years' experience in conducting evaluations in the field of health, Sexual reproductive health and rights for UN agencies and/or other international organizations; • At least 7 years' professional experience preferably in programme/project management in the public sector at national level. • Good knowledge of issues of reproductive health and rights and how this impacts on women and the young. • Experience in working with government institutions, NGOs and/or donor institutions. • Experience in leading and / or advising on the implementation of public health programmes or projects, particularly in the area of reproductive health, maternal health and adolescents and youth • Working experience in the Kenya Health sector; • Excellent data analysis skills in qualitative and quantitative methods. • Excellent report writing skills. • Familiarity with UN operations; • Ability to work in a team. **Important Note:** • The consultancy involves desk work, which the consultants are expected to deliver using own equipment and work space.
Inputs/ services to be provided by UNFPA	Review of tools/ reports with timely comments; oversight of field activities. The field visits shall be facilitated by and arranged in consultation with UNFPA. UNFPA will facilitate logistics for the stakeholders 'meetings.

Other relevant information or special conditions, if any

Remuneration and Duration of contract
Payments shall be done in 3 phases: upon submission of the following reports:
Upon approval of the Design Report 20%
Upon satisfactory contribution to the draft evaluation report 40%
Upon submission of the final End Term Evaluation report 40%
UN Consultancy Rates for Local Consultants and Experts will apply.

	Lead Consultant	**SRH Specialist**
Desk review and drafting of inception report	4 days	3 days
Field phase (data collection)	24 days	24 days
Drafting the report	8 days	5 days
Dissemination/stakeholder meeting	1	1
	37 days	**33 days**

Final report shall be submitted to UNFPA no later than 25 September, 2020

Annex 2: List of persons/institutions met

Key Informants and Focus Groups

Type of Stakeholder: UNH6 Partners			
Organisation/ Agency	**Interviewee**	**Position**	**Consultant**
UN RCO	Siddharth Chatterjee	Resident Coordinator	SM
UNFPA	Dr. Ademola Olajide	UNFPA Country Representative	SM & CM
	Dr. Rael Mutai	Senior Programme Coordinator	
	Zipporah Gathithi	Programme Specialist M&E	
	Dr. Dan Okoro	Programme Specialist, Reproductive Health	
	Stine Vest Nielsen	Programme Analyst	
WHO	Dr, Rudi Eggers	WHO Representative	SM
	Dr. Joyce Lavissa	National Professional Officer MNHSRH, ASRH,	
	Dr. Joseph Chabi	Child and Adolescent Health & Nutrition	
UNAIDS	Medhin Tsehaiu	UNAIDS Country Coordinator	SM & CM
UN Women	Anna Mutavati	UN Women Representative	SM & CM
	Grace Wangechi		
	Stephen Githaiga		
UNICEF	Maniza Zaman	UNICEF Country Representative	SM & CM
	Dr. Khadija Abdalla	MNH Specialist	
	Judith Raburu	Child Health Officer	
Government of Kenya and Parastatals			
MOH	Dr. Bashir Issak	Head, RMCA	SM & CM
NCPD	Dr. Sheikh Mohamed	Director General	SM & CM
	Peter Arisi Nyakwara	Director Technical Services	
Type of Stakeholder: International Development Partners and Donors			
USAID	Sheila Macharia	Director – Family Health	SM & CM
FCDO	Milka Choge	Health Advisor for FCDO Kenya	SM & CM
Type of Stakeholder: Implementing Partners and Civil Society			
Isiolo County	Amina Falana	RH Coordinator	SM & CM
	Francisca Akope	Deputy RH Coordinator	
	Philip Mugo	NACC Coordinator	
	Dr. Abubakar Mohamed	Director of Health	
	Wario Galma	CEC- Health	
	Ali Jillo	M & E Coordinator & Former JP County Coordinator	
MENKEN	Catherine Githae	Programme officer	CM
	Robert Sonkolo	Male Champion	SM
Lamu County	Dr. Victor Tole	Ag Chief Officer – Health & Public Health Services	SM & CM
	Bahati Mburah	County Nursing Officer	
	Abdiwahab Ahmed	Former JP County Coordinator	SM
Mandera County	Hassan Mohamed	RH Coordinator	SM & CM
	Mohamed Hassan	Director of Health	

Marsabit County	Dr. Adano Kochi	Director of Health	SM & CM
	Amina Fora	M & E Coordinator & Former JP County Coordinator	
	Christine Bokayo	Director – Family Health	
	Abdi Yusuf	Director, Community Health	
Migori County	Iscar Aluoch	CEC- Health	SM & CM
	Michael Nyachae	County Director for Health	
	Jesse David	CHRIO	
	Beatrice Oloo	RH Coordinator	CM
	Lilian Njoki	Child & Adolescent coordinator	SM & CM
	Martha Awour	Former JP County Coordinator	CM
Wajir County	Mohamud Ahmed	RH Coordinator	SM & CM
Type of Stakeholder: Primary and Secondary Beneficiaries – KII & FGDs			
Isiolo County			
Nurses	KII (2)	Tupendane Dispensary	SM
CHEW	KII		CM
CHVs	FGD (7)		CM
Mothers	FGD (6)		SM
Maternity In-charge	KII (1)	Emeret Health Centre	SM & CM
Nurse In-charge	KII (1)	Kinna Health Centre	SM
MCH In-charge	KII (1)		CM
CHEW	KII (1)		SM & CM
CHVs	FGD (8)		
Mothers	FGD (7)		SM
Migori County			
Adolescents	FGD (7)	Migori County Referral Hospital Youth Centre	SM & CM
CHVs	FGD (8)	Masaba Health Centre	
TBAs	FGD(8)	Mogori Health Centre	CM
Nurse In-charge & Midwives	KII (3)	Uriri Sub county Hospital	SM
SC MOH	KII (1)		CM
CHVs	FGD (8)		SM
TBAs	FGD(8)		CM
Mothers	FGD (9)	Awendo Sub County Hospital	SM & CM
Mothers	Case stories (3)		
Mothers	FGD (9)	Rongo Sub County Hospital	SM & CM

SM = Sostine Makunja; CM = Calistus Masika

Annex 3: List of documents consulted

1. Terms of Reference for the Evaluation of the Un H6 Joint Programme Reproductive, Maternal, Newborn, Child And Adolescent Health (RMNCAH) 2015-2020
2. General Information about Kenya/ https://www.un.int/kenya/kenya/general-information-about-kenya
3. USAID: Agriculture and Food Security/ https://www.usaid.gov/documents/1860/agriculture-and-food-security
4. 2019 Kenya Population and Housing Census Results/ https://www.knbs.or.ke/?p=5621
5. World Bank/https://data.worldbank.org/indicator/SP.POP.TOTL?locations=KE
6. https://thecommonwealth.org/our-member-countries/kenya/economy
7. Kenya National Bureau of Statistics, Economic Survey 2020
8. Sub national variation and inequalities in under-five mortality in Kenya (2013) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6360661/
9. NACC Kenya HIV Estimates Report 2018
10. https://data.worldbank.org/indicator/SH.STA.MMRT?locations=KE
11. Kenya Demographic and Health Surveys 2014 and 2008/9
12. UNFPA Kenya Dispatch 13 August 2014: http://kenya.unfpa.org/news/counties-highest-burden-maternal-mortality
13. Kenya Demographic and Health Survey 2014
14. UNICEF Kenya Key Demographic Indicators/ https://data.unicef.org/country/ken/
15. Kenya Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH) Investment Framework 31st January 2016
16. UNICEF: Under 5 mortality/ https://data.unicef.org/topic/child-survival/under-five-mortality/
17. Kenya Ministry of Health (2015): Kenya RMNCAH Investment Framework.
18. Mwaniki et al. (October 2010): 'An Increase in the Burden of Neonatal Admissions to a Rural District Hospital in Kenya over 19 Years', BMC Public Health, DOI: 10.1186/1471-2458-10-591
19. Black, Robert E. et al. (2013): 'Maternal and Child Undernutrition and Overweight in Low-income and Middle-income Countries', The Lancet, Vol. 382, No. 9890, pp. 427–451.
20. UNICEF: Under 5 mortality/https://data.unicef.org/topic/child-survival/under-five-mortality/
21. Multiple Indicator Cluster Survey 2011 and 2008
22. UN H6 Joint Programme document
23. UNICEF, Amoxicillin Dispersible Tablets: Market and Supply Update, 2018
24. 2019 Kenya Population and Housing Census (KPHC).
25. National ASRH Policy 2015
26. https://www.afidep.org/publication/adolescents-age-10-19-presenting-with-pregnancy-at-health-facilities/
27. https://reliefweb.int/report/kenya/covid-19-lockdown-linked-high-number-unintended-teen-pregnancies-kenya
28. Kenya NACC (2018): Kenya AIDS Response Progress Report, 2018
29. Wajir County HIV AND AIDS Strategic Plan: A County free of new HIV infection, stigma and discrimination. 2015/16 - 2018/19
30. Kenya HIV Estimates Report, 2018
31. Mandera County HIV and AIDS Strategic Plan 2016-2019: A healthy and productive population
32. Marsabit county HIV & AIDS strategic plan 2015/2016 - 2018/2019

33. Isiolo county AIDS strategic plan 2014/2015 - 2018/2019: *Towards Ending the HIV Epidemic in Isiolo County*
34. Lamu county HIV strategic plan 2016 - 2019: *My County my responsibility*
35. Framework for Elimination of Mother to-Child Transmission of HIV and Syphilis 2016–2021
36. Republic of Kenya, Ministry of Health (2014): *Kenya Health Policy 2014–2030: Towards Attaining the Highest Standard of Health*.
37. National AIDS Control Council/Ministry of Health (2014): Kenya AIDS Strategic Framework 2014/2015–2018/2019.
38. Kenya Ministry of Health (2015): Kenya RMNCAH Investment Framework.
39. United Nations Development Assistance Framework (UNDAF) 2018-2022Every Woman Every Child (2016): 'UN Secretary-General Announces Members of the High-Level Advisory Group for Every Woman Every Child' [Press release]. Retrieved from http://www.everywomaneverychild.org.
40. UN H4+ agencies (2014): *Improving Maternal and Newborn Outcomes in Six High Burden Maternal Mortality Counties in Kenya: Isiolo, Lamu, Mandera, Marsabit, Migori, and Wajir*, December 2014.
41. The Department for International Development of the United Kingdom and the Government of Norway.
42. Handbook: How to Design and Conduct a Country Programme Evaluation at UNFPA, DOS. October 2013. Revised Template 2019.
43. https://www.covid19businessresponse.ke/

Annex 4: Evaluation Matrix

RELEVANCE
EQ1:

a. To what extent is the RMNCAH programme adapted to national and county needs and policies?
b. To what extent did the UN RMNCAH JP address needs and priorities of beneficiaries including women of reproductive age, girls, adolescents, young people, vulnerable people, and indirectly healthcare providers? How valuable were the results to beneficiaries?
c. Has the H6 RMNCAH programme been able to adequately respond to changes in needs and priorities, and to specific requests from the national and county stakeholders?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Assumption 1: The H6 RMNCAH programme is adapted to national and county needs and policies	• H6 RMNCAH programme and AWPs reflect national and county health strategic policy goals and the core strategies • Evidence of systematic identification of the county's needs prior to the H6 RMNCAH programming. • The extent to which H6 RMNCAH programme has appropriately taken into account the priorities of the Kenya Government and key stakeholders. • Choice of beneficiaries for H6 RMNCAH programme - supported interventions are consistent with identified needs as well as national priorities in the AWPs, including women, youth and other vulnerable groups • The H6 RMNCAH programme contributes to building national and county capacities	• AWPs and annual reports • National policies/ strategy documents (e.g. Health Sector Strategic Plan 2018-2022, Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Investment Framework, National Adolescent Sexual and Reproductive Health Policy, County Health Sector Strategic Plans), Kenya Constitution • National and county government staff • UN H6 agency focal person • GOK/UNFPA 8th CPE Needs Assessment Report	• Document review • Thematic framework analysis of perspectives of national and county stakeholders • KI interviews with County Governors, UN H6, MOH, Danida, and CHMT • FGDs with primary and secondary beneficiaries

Assumption 2: The needs and priorities of beneficiaries including women of reproductive age, mothers and children, and indirectly healthcare providers, were addressed and the results were valuable to beneficiaries	• Evidence of needs and priorities of direct and indirect beneficiaries met	• AWPs and Annual reports • Healthcare providers, TBAs and with direct beneficiaries (WRA and men) ; • CHMT, former county coordinators and national MOH • Rapid needs assessment report prior to programme implementation	• Thematic framework analysis of perspectives of relevant stakeholders at national, county/facility and community level • KIIs with healthcare providers ; • FGDs with CHVs, TBAs and with direct beneficiaries (WRA and men) ; • KII with CHMT, county coordinators and national MOH
Assumption 3: The H6 RMNCAH programme has been able to adequately respond to changes in needs and priorities, and to specific requests from the national and county stakeholders.	• The speed and timeliness of response (response capacity) • Adequacy of the response (quality of the response) • Evidence of changes in programme design or interventions reflecting changes in needs of the population and priorities of MOH and stakeholders	• Annual progress reports • Annual work plans • H6 agency focal persons • County focal persons • MOH and key partners	• Document review • KI interviews • Thematic framework analysis of perspectives of relevant stakeholders at national and county level

EFFECTIVENESS AND STRATEGIC ALIGNMENT

EQ2:

a. To what extent did the interventions supported by the programme in all areas contribute to the achievement of planned results (outputs and objectives as stipulated in the results framework)?
b. To what extent has H6 RMNCAH programme supported interventions contributed to the capacity development and service delivery in the 6 Counties and addressed the most pertinent needs?
c. Were there any unintended results, positive and/or negative, of the H6 RMNCAH programme?
d. To what extent are the H6 partners coordinated for effective delivery of the RMNCAH programme
e. To what extent are the H6 partners strategically aligned with other UN Agencies for effective UN Coherence

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Assumption 1: The H6 RMNCAH programme supported interventions contributed to the capacity development and service delivery in the 6 Counties and addressed the most pertinent needs	• Extent to which M&E of programme achievements indicate timely meeting of outputs across the years • The extent to which outputs in the H6 RMNCAH programme and results framework are likely to have contributed to outcome results	• Secondary data sets and reports (HMIS-DHIS) • Annual progress reports • Annual JP work plans • Relevant programme, project and institutional reports of stakeholders • H6 agency focal person MOH, IPs and beneficiaries	• Document review of secondary data: Trend analysis of outputs against targets (disaggregated by geographical area/target group/age/sex) • KI interviews (UN H6 agencies, CHMT, MOH national) • FGDs with beneficiaries

Assumption 2: The H6 RMNCAH programme supported interventions contributed to the capacity development and service delivery in the 6 Counties and addressed the most pertinent needs	• Evidence of capacity development initiatives supported by H6 RMNCAH programme and of the likelihood of sustainable results (e.g. staff retention, continued finance, improved quality of service) • Evidence of ongoing benefits after the interventions have ended	• Annual progress reports • Annual JP work plans • H6 agency focal persons • MOH and IPs	• Document review • KI Interviews (UN H6 agencies, CHMT, MOH national) • FGDs with indirect beneficiaries (Midwives, TBAs, CHVs) • Thematic framework analysis of perspectives of relevant stakeholders especially Midwives, TBAs, CHVs •
Assumption 3: Any unintended results, positive and/ or negative, of the H6 RMNCAH programme have been documented and, where necessary, amendments to the programme implemented or planned	• Evidence of unforeseen consequences in programme and project reports and assessments • Evidence of unforeseen consequences provided by KIs and/ or beneficiaries	• AWPs and APRs • H6 agency focal persons • MOH and key stakeholders	• Thematic framework analysis of perspectives of relevant stakeholders at national, county/facility and community level • Document review • KI interviews (UN H6 agencies, CHMT, MOH national) • FGDs with beneficiaries, TBAs, CHVs
Assumption 4: The H6 partners were well coordinated and coherent for effective delivery of the RMNCAH programme intended results	• Evidence of strategic coordination and coherence towards achievement of planned interventions	• H6 agency focal persons • MOH and key stakeholders	• Thematic framework analysis of perspectives of relevant stakeholders at national, county/facility level • KI interviews (UN H6 agencies, CHMT, MOH national) •

EFFICIENCY

EQ3:

a. To what extent have the H6 Partners made good use of its human, financial and technical resources to pursue the achievement of the objectives defined in the RMNCAH programme document?
b. Were the available resources adequate to meet RMNCAH JP Needs? Was the approach used to support the county efficient? Are there more efficient ways and means of delivering more and better results (outputs and outcomes) with the available inputs? Could a different approach have produced better results?
c. Did project activities overlap and duplicate other similar interventions (funded/supported by other donors?)

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Assumption 1: Implementing partners received H6 RMNCAH programme financial and technical support as planned and in a timely manner	• The financial resources were received to the level planned in the AWPs and in a timely manner • Quality technical assistance to build capacity was available to the level planned • Evidence that technical assistance increased capacity among recipient stakeholders	• AWPs and APRs, • MOH reports • H6 agency financial reports • H6 agency focal persons • IP staff /CHMT • Beneficiaries	• Document review • KI interviews (UN H6 agencies, CHMT, MOH national) • FGDs with beneficiaries • Thematic framework analysis of perspectives of relevant stakeholders at national, county/facility and community level
Assumption 2: Administrative, procurement and financial procedures as well as the mix of implementation modalities led to efficient execution of programme activities.	• Evidence of implementation done as per plans and budget throughout its implementation period • Appropriateness of H6 administrative, procurement and financial procedures • Appropriateness of IP selection criteria	• Proposed budgets and expenditure data 2015-2020 • AWPs and budget • APRs • H6 agency focal persons • IP staff /CHMT	• Document review • KI interviews • Costing outline by intervention/thematic area/ county/IP and by year
Assumption 3: The resources were adequate to meet RMNCAH JP needs, best delivery approach was used, and there was no overlap/ duplication of interventions	• Evidence of adequacy of resources to meet key interventions planned • Evidence of no overlap/duplication of interventions funded by other donors	• UN H6, county IPs, national MOH, beneficiaries	• Thematic framework analysis of perspectives of relevant stakeholders at national, county/facility and community level • KI interviews (UN H6, county IPs, national MOH, beneficiaries)

SUSTAINABILITY

EQ4:

a. To what extent have the partnerships established by RMNCAH programme promoted the national/ county ownership of supported interventions, programmes and policies?
b. To what extent are the benefits of the programme likely to be sustained by the county government after the completion of this partnership i.e. beyond 2020?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Assumption 1: The H6 RMNCAH programme has contributed to increased national and county ownership and to relevant national/ county policies, strategies and plans as well as the incorporation into wider development policies and programming Assumption 2: The benefits of the programme are likely to be sustained by the county government after the completion of this partnership i.e. beyond 2020	• Evidence of active H6 RMNCAH programme involvement regarding policy, strategy and plan development in its 3 outcome areas • Evidence in policies, strategies and plans of increased incorporation of the programme areas of the H6 RMNCAH programme • Evidence of ongoing benefits after the interventions have ended • Evidence of other sustainability measures like increased budgetary allocation to RMNCAH areas • Evidence of capacity development initiatives supported by H6 RMNCAH programme and of the likelihood of sustainable results (e.g. staff retention, continued finance, improved quality of service)	• Analysis of county government budget allocations • Annual work plans and APRs • National, sectoral and county policies, plans, and reports • National/County focal persons	• Thematic framework analysis of perspectives of relevant stakeholders at national, county/facility and community level • Document review of secondary data • KI interviews (County Governors, UN H6 agencies, CHMT, MOH national)

COORDINATION & PARTNERSHIP

EQ5:

a. What are the main comparative strengths of H6 Partners in Kenya and how are these perceived by the national, County and international stakeholders?
b. To what extent are the H6 Partners coordinated in implementation of the RMNCAH programme, including adherence to the Implementation Framework?
c. To what extent are the H6 partners coordinated with other UN agencies to deliver as one, particularly in the areas of potential overlap?

Assumptions to be assessed	Indicators	Sources of information	Methods and tools for the data collection
Assumption 1: The H6 Partners have comparative strengths in Kenya and are well perceived by the national, County and international stakeholders Assumption 2: H6 Partners were well coordinated during implementation of the RMNCAH programme, including adherence to the Implementation Framework Assumption 3: That the H6 RMNCAH programme contributed to effective coordination between IPs Assumption 4: The H6 RMNCAH programme has effectively contributed to the UNCT and its effort to achieve the goal of delivering as one	• Evidence of individual H6 partners adequately in engaging and working with both national, county and international stakeholders • Evidence of joint programming (including joint planning meetings, annual work plans, frameworks, supervision among H6 partners, performance reviews, and county/ national government) • Evidence of effective coordination between IPs to which H6 RMNCAH programme contributed • Evidence of work coherence amongst 6 UN agencies • Evidence of adherence to UN joint programming standard operating procedures • Evidence of roles played by each H6 partner in RMNCAH JP and active participation in programme working groups, and exchange of information • Existence/lack of overlap during implementation	• AWPs and APRs • Monitoring and evaluation reports • H6 agency focal persons • MOH, county implementing partners • Joint programmes reports and work plans	• Document review • KI interviews (County Governors, Danida, UN H6 agencies, CHMT, MOH national) • Thematic framework analysis of perspectives of relevant stakeholders at national and county level

Annex 3b: Focus Group Discussion Guide

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

Name of Participants	County	Health Facility

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

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

This FGD Guide is to be used for direct and indirect beneficiaries (Community Health Volunteers, Traditional Birth Attendants, Pregnant and breastfeeding women).

1. **General Introduction**

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

2. **Core Interview:**

• **What type of support/service/intervention did you receive from the Joint UN H6 RMNCAH programme and how did you get involved?** *Probe: Type of service or programme, length and overall experience*
• **To what extent did the support received help you? Do you know how and why the beneficiaries of the programme were selected? Do they feel that the people included in the programme deserve it?** *Probe was it responsive to your needs/Correct target? Coverage?*
• **How was the intervention/service delivered? What do you think has worked best? What has not worked well?**

• **Have you had support from other organisations doing similar work (RMNCAH) as the UN H6?** *Probe: why did you choose this joint programme implemented by Counties/IPs?*
• **In general terms, what are the current issues affecting utilisation of RMNCAH and levels of participation by women, adolescents, GBV survivors and men?** *Probe: trends in the area, levels of participation across age, gender and abilities. Challenges that are not captured by the intervention*
• **Are these programme activities/services having a lasting impact on your life? What has changed in your community since programme started?**
• **Are there ways to sustain the positive changes that you have witnessed with the services/interventions?**
• **If you were to recommend changes or ways to improve the interventions what changes would you make or like to see?**
• **Any final questions or comments you would wish to add?**

Annex 3b: Key Informant Interview Guide – County Governors

Interviewer:		Interview Code:	
Date of Interview:			
Name(s) of Interviewee:			
Name of County:			
Position(s):			

This KII Guide is to be used for interview with selected County Governors among implementing counties

Abbreviations and Acronyms

GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
MNCH	Maternal, Newborn and Child Health
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
UN H6	Partnership among UNAIDS, UNICEF, UNFPA, UN Women, WHO, and World Bank

1. Purpose/Objective and Context of the Interview

- Clarify briefly the objective of the evaluation (End Term Evaluation of Joint RMNCAH programme)
- Explain the objectives of the interview – to get more information on the progress that the Joint RMNCAH programme has made between 2015 and 2020.
- Emphasize confidentiality of the sources and of the information provided, unless the interviewee agrees to be quoted where absolutely necessary.
- Indicate the focus area – Maternal Health, Neonatal Health, Child Health, Adolescent Reproductive Health, HIV and AIDS, Gender-based violence – Main Joint programme outcome questions:

    ii. To what extent did the UNH6 programme improve access to, and quality of, integrated RMNCAH, HIV, and GBV service?

    iii. To what extent did the UNH6 programme increased demand for quality RMNCAH, HIV, and GBV services?

    iv. To what extent did the UNH6 programme strengthen institutional capacity at county and national levels for planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services?

2. Core Interview:

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

	Objective of the Question	Specific questions to be Asked	Source of Information
1	Relevance of the RMNCAH programme on alignment with County priorities and policies	The UN H6 agencies in Kenya have been working with both national and county governments towards strengthening the county capacity to plan, coordinate, fund, implement and monitor action on the integrated health agenda for women, adolescents and children. a. In your opinion, what has been the contribution of the UN H6 to the health sector in your county? • *Rollout of Universal Health Coverage in your county* • *Health services access in your county* b. To what extent is the RMNCAH programme adapted to the needs and priorities of this county? • *Your county RMNCAH mission and vision*	Governors of select County governments
2	Effectiveness of UN H6 RMNCAH programme on planned interventions in the county	The Joint Programme RMNCAH/HIV and GBV targets the six high maternal mortality and newborn counties in Kenya. a. Did the interventions supported by the programme have any positive or negative effects on health outcomes in your county?	Governors of select County governments
3	Efficiency RMNCAH programme interventions	Were the allocated resources adequate to meet UN H6 RMNCAH needs in this county?	Governors of select County governments
4	Sustainability of RMNCAH programme interventions	How will the gains made by the UN H6 RMNCAH/HIV and GBV Joint Programme on reducing maternal and newborn mortality in this county be sustained beyond the programme (2020)? *Probe for:* • *Absorption of the programme by the County Government* • *Levels of budgetary allocation for MNCH by the County Government*	Governors of select County governments
5	Lessons Learnt	What are the most notable lessons learnt from the partnership with the UN H6 JP on RMNCAH	Governors of select County governments
6	Recommendations	• What do you think can be done to make RMNCAH services better? • What are your key recommendations for future partnerships/support around RMNCAH services?	Governors of select County governments

3. Any further questions/probes:

Annex 3b: Key Informant Interview Guide – County Governors

Interviewer:		Interview Code:	
Date of Interview:			
Name(s) of Interviewee:			
Institution:			
Position(s):	Dr Sheikh Mohamed		

This KII Guide is to be used for interview with Director General - National Council for Population and Development (NCPD)

Abbreviations and Acronyms

GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
MNCH	Maternal, Newborn and Child Health
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
UN H6	Partnership among UNAIDS, UNICEF, UNFPA, UN Women, WHO, and World Bank

1. Purpose/Objective and Context of the Interview

- Clarify briefly the objective of the evaluation (End Term Evaluation of Joint RMNCAH programme)
- Explain the objectives of the interview – to get more information on the progress that the Joint RMNCAH programme has made between 2015 and 2020.
- Emphasize confidentiality of the sources and of the information provided, unless the interviewee agrees to be quoted where absolutely necessary.
- Indicate the focus area – Maternal Health, Neonatal Health, Child Health, Adolescent Reproductive Health, HIV and AIDS, Gender-based violence – Main Joint programme outcome questions:

    i. To what extent did the UNH6 programme improve access to, and quality of, integrated RMNCAH, HIV, and GBV service?

    ii. To what extent did the UNH6 programme increased demand for quality RMNCAH, HIV, and GBV services?

    iii. To what extent did the UNH6 programme strengthen institutional capacity at county and national levels for planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services?

2. Core Interview:

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

	Objective of the Question	Specific questions to be Asked	Source of Information
1	Relevance of the RMNCAH programme on alignment with Country priorities and policies	The UN H6 agencies in Kenya have been working with both national and county governments towards strengthening the county capacity to plan, coordinate, fund, implement and monitor action on the integrated health agenda for women, adolescents and children. *In your opinion, what has been the contribution of the UN H6 to the health sector in kenya especially towards advancing RMNCAH/HIV and GBV priorities in Kenya?*	Director General -NCPD
2	Effectiveness of UN H6 RMNCAH programme on planned interventions in the country	The Joint Programme RMNCAH/HIV and GBV targets the six high maternal mortality and newborn counties in Kenya. *Did the interventions supported by the programme have any positive or negative effects on health outcomes in your county?*	Director General -NCPD
3	Effectiveness of UN H6 RMNCAH programme advocacy efforts	The National Council for Population and Development (NCPD) collaborated with UNFPA in the advocacy campaign to end preventable maternal deaths in the high burden counties in Kenya. Some of the key interventions included the convening of high level policy dialogue forums on RMNCAH, signing of the joined communique by Governors of the 15 highest MMR burden counties and in promoting strategic targeting of resources and investments to marginalized counties with the greatest needs. *In your opinion, to what extent have the UN H6 Partners succeeded in advocacy efforts towards bringing prominence on the issue of maternal and newborn health under the Joint Programme on RMNCAH*	Director General -NCPD
4	Sustainability of RMNCAH programme interventions	How will the gains made by the UN H6 RMNCAH/ HIV and GBV Joint Programme on reducing maternal and newborn mortality in Kenya be sustained beyond the programme (2020)?	Director General -NCPD
5	Lessons Learnt	What are the most notable lessons learnt from the partnership with the UN H6 JP on RMNCAH	Director General -NCPD
6	Recommendations	What are your key recommendations for future partnerships/support around RMNCAH services? • *Advocacy, Financing?* • *Building back better in the context of crisis such as COVID19?*	Director General -NCPD

3. Any further questions/probes:

Annex 3b: Key Informant Interview Guide – County Governors

Interviewer:		Interview Code:	
Date of Interview:			
Name(s) of Interviewee:			
Institution:			
Position(s):	Dr Sheikh Mohamed		

This KII Guide is to be used for interview with Director General - National Council for Population and Development (NCPD)

Abbreviations and Acronyms

GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
MNCH	Maternal, Newborn and Child Health
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
UN H6	Partnership among UNAIDS, UNICEF, UNFPA, UN Women, WHO, and World Bank

1. Purpose/Objective and Context of the Interview

- Clarify briefly the objective of the evaluation (End Term Evaluation of Joint RMNCAH programme)
- Explain the objectives of the interview – to get more information on the progress that the Joint RMNCAH programme has made between 2015 and 2020.
- Emphasize confidentiality of the sources and of the information provided, unless the interviewee agrees to be quoted where absolutely necessary.
- Indicate the focus area – Maternal Health, Neonatal Health, Child Health, Adolescent Reproductive Health, HIV and AIDS, Gender-based violence – Main Joint programme outcome questions:

    i. To what extent did the UNH6 programme improve access to, and quality of, integrated RMNCAH, HIV, and GBV service?

    ii. To what extent did the UNH6 programme increased demand for quality RMNCAH, HIV, and GBV services?

    iii. To what extent did the UNH6 programme strengthen institutional capacity at county and national levels for planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services?

2. Core Interview:

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

	Objective of the Question	Specific questions to be Asked	Source of Information
1	Relevance of the RMNCAH programme on alignment with Country priorities and policies	The UN H6 agencies in Kenya have been working with both national and county governments towards strengthening the county capacity to plan, coordinate, fund, implement and monitor action on the integrated health agenda for women, adolescents and children. *In your opinion, what has been the contribution of the UN H6 to the health sector in kenya especially towards advancing RMNCAH/HIV and GBV priorities in Kenya?*	Director General -NCPD
2	Effectiveness of UN H6 RMNCAH programme on planned interventions in the country	The Joint Programme RMNCAH/HIV and GBV targets the six high maternal mortality and newborn counties in Kenya. *Did the interventions supported by the programme have any positive or negative effects on health outcomes in your county?*	Director General -NCPD
3	Effectiveness of UN H6 RMNCAH programme advocacy efforts	The National Council for Population and Development (NCPD) collaborated with UNFPA in the advocacy campaign to end preventable maternal deaths in the high burden counties in Kenya. Some of the key interventions included the convening of high level policy dialogue forums on RMNCAH, signing of the joined communique by Governors of the 15 highest MMR burden counties and in promoting strategic targeting of resources and investments to marginalized counties with the greatest needs. *In your opinion, to what extent have the UN H6 Partners succeeded in advocacy efforts towards bringing prominence on the issue of maternal and newborn health under the Joint Programme on RMNCAH*	Director General -NCPD
4	Sustainability of RMNCAH programme interventions	How will the gains made by the UN H6 RMNCAH/HIV and GBV Joint Programme on reducing maternal and newborn mortality in Kenya be sustained beyond the programme (2020)?	Director General -NCPD
5	Lessons Learnt	What are the most notable lessons learnt from the partnership with the UN H6 JP on RMNCAH	Director General -NCPD
6	Recommendations	What are your key recommendations for future partnerships/support around RMNCAH services? • *Advocacy, Financing?* • *Building back better in the context of crisis such as COVID19?*	Director General -NCPD

3. Any further questions/probes:

Annex 3b: Key Informant Interview Guide – GFF partners and key donors

Interviewer:		Interview Code:	
Date of Interview:			
Name(s) of Interviewee:			
UN Agency:			
Position(s):			

This KII Guide is to be used for **GFF partners and key donors**.

1. Purpose/Objective and Context of the Interview

- Clarify briefly the objective of the evaluation (End Term Evaluation of Joint RMNCAH programme)
- Explain the objectives of the interview – to get more information on the progress that the Joint RMNCAH programme has made between 2015 and 2020.
- Emphasize confidentiality of the sources and of the information provided, unless the interviewee agrees to be quoted where absolutely necessary.
- Indicate the focus area – Maternal Health, Neonatal Health, Child Health, Adolescent Reproductive Health, HIV and AIDS, Gender-based violence – for orientation purposes:
    i. To what extent did the UNH6 programme improve access to, and quality of, integrated RMNCAH, HIV, and GBV service?
    ii. To what extent did the UNH6 programme increased demand for quality RMNCAH, HIV, and GBV services?
    iii. To what extent did the UNH6 programme strengthen institutional capacity at county and national levels for planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services?

2. Core Interview:

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

	Objective of the Question	Specific questions to be Asked	Source of Information
1	Relevance of the RMNCAH programmes alignment with: • SDGs • National laws, policies, and population needs. • Stakeholder priorities	Kenya has made significant progress in RMNCAH/HIV and GBV in the last decade and the country has put measures in place towards realization of national vision 2030 and the SDGs. *What are the national priorities and strategies for realization of SDG 3 indicators especially in regards to RMNCAH?*	GFF partners and key donors
2	Effectiveness of GFF funded programmes	The UNH6 Joint Programme on RMNCAH/ HIV and GBV which was developed under the Global Financing Facility (GFF) Framework targets the six high maternal mortality and newborn counties in Kenya.	GFF partners and key donors

		What has been the impact of the joint programmes under the Global Financing Facility framework on MNCH indicators in the Kenya? Delivering integrated policy advice and strengthening accountability are at the heart of the GFF Framework. *What is the single most important aspect of such initiatives and why?*	
3	Efficiency agencies in implementation of the RMNCAH programmes	In general terms, to what extent are GFF funded programmes efficient in utilisation of allocated resources to achieve the RMNCAH JP objectives? Are the available resources for RMNCAH, GBV and HIV programmes adequate to meet needs in Kenya?	GFF partners and key donors
4	Coordination of GFF funded programmes in implementation of the RMNCAH programme	The UN H6 utilized the Delivering as One (DaO) approach. How successful has this approach been in Kenya? To what extent have the GFF funded programmes on RMNCAH, GBV and HIV programmes facilitated synergies and avoided duplications with interventions and strategies promoted by other UN agencies and development partner? What are your thoughts on resource mobilization for similar interventions? Who is responsible or how can the agencies better collaborate?	GFF partners and key donors
5	Sustainability of GFF funded programmes supported interventions at county and National levels	How can the gains made by GFF funded programmes on RMNCAH, GBV and HIV programmes targeting the high maternal mortality and newborn counties in Kenya be sustained beyond the programmes? How can GFF partners and donors support the counties/countries especially in developing countries given that the felt needs remain enormous? To what extent have the partnerships established under the GFF framework promoted the county/country ownership of supported interventions, programmes and policies?	GFF partners and key donors
6	Lessons Learnt	What are the most notable lessons learnt during implementation of GFF funded programmes on RMNCAH.	GFF partners and key donors
7	Recommendations	What are the key recommendations for future partnerships/support around RMNCAH programming?	GFF partners and key donors

3. Any further questions/probes:

Annex 3b: Key Informant Interview Guide – UN H6 Heads of Agencies

Interviewer:		Interview Code:	
Date of Interview:			
Name(s) of Interviewee:			
UN Agency:			
Position(s):			

This KII Guide is to be used for UN H6 Heads of Agencies (UNFPA/WHO/UNICEF/UN women/ UNAIDS, World Bank).

1. Purpose/Objective and Context of the Interview

- Clarify briefly the objective of the evaluation (End Term Evaluation of Joint RMNCAH programme)
- Explain the objectives of the interview – to get more information on the progress that the Joint RMNCAH programme has made between 2015 and 2020.
- Emphasize confidentiality of the sources and of the information provided, unless the interviewee agrees to be quoted where absolutely necessary.
- Indicate the focus area – Maternal Health, Neonatal Health, Child Health, Adolescent Reproductive Health, HIV and AIDS, Gender-based violence – for orientation purposes:

  i. To what extent did the UNH6 programme improve access to, and quality of, integrated RMNCAH, HIV, and GBV service?

  ii. To what extent did the UNH6 programme increased demand for quality RMNCAH, HIV, and GBV services?

  iii. To what extent did the UNH6 programme strengthen institutional capacity at county and national levels for planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services?

2. Core Interview:

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

	Objective of the Question	Specific questions to be Asked	Source of Information
1	Relevance of the RMNCAH programme alignment with: • SDGs • National laws, policies, and population needs. • Stakeholder priorities	The UN H6 has a responsive, flexible structure relying extensively on virtual teams and networks to strengthen the country capacity to plan, coordinate, fund, implement and monitor action on the integrated health agenda for women, adolescents and children. In your opinion, what has been the contribution of the UN H6 to the health sector in Kenya? Kenya has made significant progress in RMNCAH/HIV and GBV in the last decade and the country has put measures in place towards realization of national vision 2030 and the SDGs. What are the national priorities and strategies for realization of SDG 3 indicators especially in regards to RMNCAH?	UN H6 Heads of Agencies

2	Effectiveness of UNH6 RMNCAH programme supported interventions at county and National levels	The Joint Programme RMNCAH/HIV and GBV targets the six high maternal mortality and newborn counties in Kenya. What has been the impact of the programme on MNCH indicators in the select counties? Delivering integrated policy advice and strengthening accountability are at the heart of the H6 model. For (**UNFPA/WHO/UNICEF/UN women/ UNAIDS, World Bank)** what is the single most important aspect of this initiative and why?	UN H6 Heads of Agencies
3	Efficiency agencies in implementation of the RMNCAH programme	Were the allocated resources used efficiently to achieve the RMNCAH JP objectives? Are the available resources adequate to meet JP needs?	UN H6 Heads of Agencies
4	Coordination of H6 agencies in implementation of the RMNCAH programme	The UN H6 utilizes Delivering as One (DaO) approach. How successful has this approach been in Kenya? To what extent has the JP facilitated synergies and avoided duplications with interventions and strategies promoted by other UN agencies and development partner? What are your thoughts on resource mobilization for similar interventions? Who is responsible or how can the agencies better collaborate?	UN H6 Heads of Agencies
5	Sustainability of UNH6 RMNCAH programme supported interventions at county and National levels	How will the gains made by Joint Programme RMNCAH/HIV and GBV targeting the six high maternal mortality and newborn counties in Kenya be sustained beyond the programme? How will the agency support the counties after 2020 given that the felt needs remain enormous? To what extent have the partnership established by RMNCAH programme promoted the county ownership of supported interventions, programmes and policies?	UN H6 Heads of Agencies
6	Lessons Learnt	What are the most notable lessons learnt during implementation of UN H6 JP on RMNCAH.	UN H6 Heads of Agencies
7	Recommendations	What are the key recommendations for future partnerships/support around RMNCAH programming?	UN H6 Heads of Agencies

3. Any further questions/probes:

1. What are their thoughts on resource mobilization for similar interventions? Who is responsible or how can the agencies better collaborate?

    - Sustainability of the gains? - How will the agency support the counties after 2020 given that the felt needs remain enormous?

Annex 3b: Key Informant Interview Guide – UN H6 Heads of Agencies

Interviewer:		Interview Code:	
Date of Interview:			
Name(s) of Interviewee:			
UN Agency:			
Position(s):			

This KII Guide is to be used for **UN H6 Heads of Agencies** (UNFPA/WHO/UNICEF/UN women/ UNAIDS, World Bank).

1. Purpose/Objective and Context of the Interview

- Clarify briefly the objective of the evaluation (End Term Evaluation of Joint RMNCAH programme)
- Explain the objectives of the interview – to get more information on the progress that the Joint RMNCAH programme has made between 2015 and 2020.
- Emphasize confidentiality of the sources and of the information provided, unless the interviewee agrees to be quoted where absolutely necessary.
- Indicate the focus area – Maternal Health, Neonatal Health, Child Health, Adolescent Reproductive Health, HIV and AIDS, Gender-based violence – for orientation purposes:

  i. To what extent did the UNH6 programme improve access to, and quality of, integrated RMNCAH, HIV, and GBV service?

  ii. To what extent did the UNH6 programme increased demand for quality RMNCAH, HIV, and GBV services?

  iii. To what extent did the UNH6 programme strengthen institutional capacity at county and national levels for planning and budgeting, coordination, supportive supervision, and monitoring and evaluation of RMNCAH, HIV, and GBV services?

2. Core Interview:

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

	Objective of the Question	Specific questions to be Asked	Source of Information
1	Relevance of the RMNCAH programme alignment with: • SDGs • National laws, policies, and population needs. • Stakeholder priorities	The UN H6 has a responsive, flexible structure relying extensively on virtual teams and networks to strengthen the country capacity to plan, coordinate, fund, implement and monitor action on the integrated health agenda for women, adolescents and children. In your opinion, what has been the contribution of the UN H6 to the health sector in Kenya? Kenya has made significant progress in RMNCAH/ HIV and GBV in the last decade and the country has put measures in place towards realization of national vision 2030 and the SDGs. What are the national priorities and strategies for realization of SDG 3 indicators especially in regards to RMNCAH?	UN H6 Heads of Agencies

2	Effectiveness of UNH6 RMNCAH programme supported interventions at county and National levels	The Joint Programme RMNCAH/HIV and GBV targets the six high maternal mortality and newborn counties in Kenya. What has been the impact of the programme on MNCH indicators in the select counties? Delivering integrated policy advice and strengthening accountability are at the heart of the H6 model. For (**UNFPA/WHO/UNICEF/UN women/ UNAIDS, World Bank)** what is the single most important aspect of this initiative and why?	UN H6 Heads of Agencies
3	Efficiency agencies in implementation of the RMNCAH programme	Were the allocated resources used efficiently to achieve the RMNCAH JP objectives? Are the available resources adequate to meet JP needs?	UN H6 Heads of Agencies
4	Coordination of H6 agencies in implementation of the RMNCAH programme	The UN H6 utilizes Delivering as One (DaO) approach. How successful has this approach been in Kenya? To what extent has the JP facilitated synergies and avoided duplications with interventions and strategies promoted by other UN agencies and development partner?	UN H6 Heads of Agencies
5	Sustainability of UNH6 RMNCAH programme supported interventions at county and National levels	How will the gains made by Joint Programme RMNCAH/HIV and GBV targeting the six high maternal mortality and newborn counties in Kenya be sustained beyond the programme? To what extent have the partnership established by RMNCAH programme promoted the county ownership of supported interventions, programmes and policies?	UN H6 Heads of Agencies
6	Lessons Learnt	What are the most notable lessons learnt during implementation of UN H6 JP on RMNCAH.	UN H6 Heads of Agencies
7	Recommendations	What are the key recommendations for future partnerships/support around RMNCAH programming?	UN H6 Heads of Agencies

3. Any further questions/probes:

Outcome area	Indicator Name	Indicator Description	County	Target 2020	2016 (Baseline)	2017	2018 (Midterm)	2019	2020 (Endterm)
Overall Joint Programme Outcome Indicators	**Overall Outcome Indicator (OOI) 1:** Pregnant women attending at least four ANC visits (percentage)	Proportion of women between the ages of 15-49 years who had at least 4 ANC visits attended by trained health personnel	Isiolo	80%	85%	69%	89%	85%	73%
			Lamu	80%	61%	52%	69%	53%	64%
			Mandera	50%	12%	17%	23%	39%	24%
			Marsabit	49%	37%	28%	56%	49%	46%
			Migori	60%	36%	30%	51%	55%	68%
			Wajir	38%	25%	25%	33%	32%	64%
	OOI.2: Births attended by skilled health personnel (percentage)	Proportion of births attended by skilled health personnel	Isiolo	87%	67%	50%	76%	73%	62%
			Lamu	90%	64%	87%	87%	85%	89%
			Mandera	70%	29%	31%	39%	61%	48%
			Marsabit	69%	49%	38%	69%	71%	61%
			Migori	80%	60%	58%	76%	76%	85%
			Wajir	51%	31%	42%	44%	43%	43%
	OOI.3: Women of reproductive age living with HIV who are on antiretroviral treatment (percentage)	Proportion of women of reproductive age living with HIV who are enrolled in antiretroviral treatment (ART)	Isiolo	80%	101%	126%	96%	93%	93%
			Lamu	1557	1223	1191	1406	1567	1594
			Mandera	0.2%	1.2%	0.8%	0.8%	0.7%	0.5%
			Marsabit	77%	57%	27%	30%	31%	39%
			Migori	100%	96%	98%	99%	99%	98%
			Wajir	14%	8%	7%	10%	13%	20%
	OOI.4: Births registered (percentage)	Proportion of births which are registered through the proper channels	Isiolo	70%	43%	61%	62%	67%	67%
			Lamu	**	60%	98%	100%	100%	96%
			Mandera	70%	50%	60%	65%	68%	40%
			Marsabit	**	**	**	**	**	**
			Migori	100%	59%	57%	75%	75%	56%
			Wajir	24%	18%	16%	20%	22%	40%
Intermediate Outcome 1: Improved access to and quality of integrated RMNCAH services, including HIV and GBV services	**Intermediate Outcome Indicator (IOI) 1.1:** Facilities (L2-L4) providing basic emergency obstetric and newborn care (BEMONC) (percentage)	Proportion of L2 to L4 health facilities that provide the entire package of BEmONC services	Isiolo	77%	54%	54%	54%	59%	59%
			Lamu	100%	60%	67%	73%	82%	88%
			Mandera	65%	38%	40%	48%	55%	60%
			Marsabit	100%	50%	50%	50%	56%	64%
			Migori	80%	36%	68%	50%	70%	**
			Wajir	94%	79%	73%	89%	**	56%

	IOI.1.2: Percentage of pregnant women who were tested for HIV and received their results – during pregnancy, during labour and delivery, and during the post-partum period	Proportion of ANC clients tested for HIV among new ANC clients coverage (shown in bracket, highlighted yellow)	Isiolo	80%	85%	69%	89%	85%	73%
			Lamu	58%	43%	97%	97%	98%	99%
			Mandera	80%	40%	55%	65%	70%	55%
			Marsabit	80%	68%	71%	91%	75%	76%
			Migori	90%	88%	84%	84%	86%	88%
			Wajir	48%	28%	22%	19%	43%	46%
	IOI.1.3: Number of GBV survivors treated in health facilities (number)	Number of survivors of GBV who attend health facilities where they have received the full package of GBV health sector services	Isiolo	50% **	111	44	82	111	58
			Lamu	**	**	16	5	6	23
			Mandera	**	5	12	15	20	10
			Marsabit	40%**	1	3	5	26	15
			Migori	50%**	264	227	332	365	376
			Wajir	15%**	2	14	8	10	20
Intermediate Outcome 2: Increased demand for RMNCAH services, including HIV and GBV services	**IOI.2.1:** Women of reproductive age receiving modern family planning (new users) (number)	Number of women aged 15–49 who receive modern family planning	Isiolo	4132	6188	4946	9648	9664	6906
			Lamu	80% **	4539	3885	5391	5722	3354
			Mandera	7519	6030	7791	18272	12689	5158
			Marsabit	6538	5738	7983	19279	10318	4552
			Migori	134813	151,665	124,912	153,833	151,532	119,078
			Wajir	9613	8113	6,107	4,713	9,516	9,832
	IOI.2.2: Adolescent girls supported to return to school after pregnancy (number)	Number of girls aged 14 to 19 who return to school after pregnancy	Isiolo	**	**	**	**	**	**
			Lamu	150	**	**	50	98	**
			Mandera	**	**	**	**	**	**
			Marsabit	**	**	**	**	**	**
			Migori	20	14,196	12,285	12,331	10,199	6,353
			Wajir	**	No programmatic support for Wajir county				

	IOI.2.3: Women and men aged 15 years and older who received HIV testing and counselling in the last 12 months and know their results (number)	Number of women and men aged 15 years and above who received HIV testing and counselling in the last year and know their results	Isiolo	10994	16907	9509	31082	18303	6754
			Lamu	90%	17141	**	**	22058	8162
			Mandera	**	8524	9053	24641	18414	6033
			Marsabit	13828	20584	17107	60266	33152	12805
			Migori	273205	36,268	30,738	36,224	38,264	32,436
			Wajir	No programmatic support for Wajir county					
	IOI.2.4: Counties that launched the HeForShe Campaign, identified local champions as trainers of trainers, and supported the mentorship programme for young people (e.g. health sector, male youth leaders, prominent business people, local media personalities, county executives, religious leaders)	Number of counties with HeForShe RMNCAH Champions, who have launched the campaign and organized trainers and trainers of trainers to influence the reproductive health services uptake by women of childbearing age in the county.	Isiolo	1	1	1	1	1	1
			Lamu	N/A	N/A	N/A	N/A	N/A	N/A
			Mandera	1	0	0	1	1	1
			Marsabit	1	1	1	1	1	1
			Migori	**	**	**	**	**	**
			Wajir	1	0	0	1	0	1

Intermediate Outcome 3: Strengthened county and national capacity for coordination, planning, supervision, monitoring, and evaluation of RMNCAH services, including HIV and GBV services	**IOI.3.1:** Counties with RMNCAH, HIV, and GBV interventions integrated into the county annual work plans for the health sector (number)	Number of Counties with RMNCAH, HIV, and GBV interventions integrated into the county annual work plans for the health sector	6 Target counties	6	6	6	6	6	6
	IOI.3.2: County health expenditure on health (percentage)	Proportion of overall county expenditure that is allocated to the health sector	Isiolo	25%	22%	22%	26%	26%	26%
			Lamu	35%	28%	24%	29%	35%	32%
			Mandera	22%	15%	18%	19%	20%	21%
			Marsabit	30%	23%	23%	25%	25%	25%
			Migori	30%	24%	25%			27%
			Wajir	24%	18%	20%	21%	21%	22%
	IOI.3.3: Counties with a functional maternal and perinatal death surveillance and response (MPDSR) system and that have used the results to take policy decisions (number)	Number of counties with a functional MPDSR system that have actually used the results to influence policies and activities in the county. Functional is defined as: Existence of MPDSR committees at community facility, sub county, and county level; Regular committee meetings; Implementation of the audits; Audit data reviewed; Use of audit data for decision making.	6	6		6	6	6	6
			Isiolo						
			Lamu						
			Mandera						
			Marsabit						
			Migori						
			Wajir						

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