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Revised country programme document

Kenya

Summary

The Executive Director presents the revised country programme document (CPD) for Kenya for final approval by the Executive Board. At the annual session of 2003, the Board commented on the draft CPD and approved the aggregate indicative budget for the country programme. In accordance with decision 2002/4 (E/ICEF/2002/8), the draft CPD has been revised, taking into account, as appropriate, comments made by delegations during that session and a summary results matrix has been added.

Decision 2002/4 also states that the present document will be approved by the Executive Board at the first regular session of 2004 on a no objection basis, unless at least five members have informed the secretariat in writing, by 12 December 2003, of their wish to bring the country programme before the Board.

<i>Basic data</i> (2001 unless otherwise stated)	
Child population (millions, under 18 years)	15.9
U5MR (per 1,000 live births)	122
Underweight (% , moderate and severe) (2000)	21
Maternal mortality ratio (per 100,000 live births) (1989-1998)	590
Primary school attendance (% net, male/female) (2000)	73/75
Primary school children reaching grade 5 (%) (1994)	68
Use of improved drinking water sources (%) (2000)	57
Adult HIV prevalence rate (%)	15.0
Child work (% , 5-14 year-olds) (2000)	36
GNI per capita (US\$)	340
One-year-olds immunized against DPT3 (%)	76
One-year-olds immunized against measles (%)	76

The situation of children and women

1. There are 31 million Kenyans, and the number grows by 2.49 per cent every year. Over one half of the people, including almost 9 million children, live below the poverty line. Their caregivers only have access to quality services where they are provided free of charge. While total fertility rates declined from 8 in the early 1980s to 4, under-five mortality has not declined in the 1990s. Sero-surveillance data from antenatal sentinel surveillance sites suggest a decline in HIV prevalence from 13.5 per cent in 2001 to 10.1 per cent in 2002 (8.7 per cent in rural areas and 12.4 in urban areas), but rates of over 30 per cent are still seen some parts of the country. The decline among those in the age group 15-24 years is more marked than in other age groups. **These trends will be validated when the population-based results of HIV tests undertaken in a recently completed Demographic and Health Survey are released later this year.** By 2001, 1.5 million Kenyans had died of AIDS, leaving over 1 million orphans, with a doubling predicted by 2010. National random sample data on HIV prevalence will be available by mid-2003.

2. Kenya is in the midst of a major political transition. In December 2002 the National Alliance Rainbow Coalition (NARC), a coalition of 17 parties, defeated KANU (Kenya African National Union) which had ruled Kenya for 40 years. The NARC manifesto calls for the elimination of corruption, trimming of the civil service, devolution of power to the regions, free primary education, reduction of interest on domestic borrowing, cheaper electricity and a new constitution. Economic recovery is expected to gather momentum in 2003 and continue into the medium term, particularly with the combined implementation of various reform measures and a peaceful political transition. **A long-term decline in donor aid is reversing, with over \$100 million received as grants from the World Bank, DFID, SIDA and UNICEF, among others to support free primary education. Now that the honeymoon period for the new Government is over much will depend on the extent to which the NARC coalition will manage to live up to the ideals it presented in its manifesto.**

3. The economic recovery strategies are being implemented against a backdrop of difficult circumstances. These include a 10-year decline in the economy, caused by an inefficient public sector; widespread corruption; high crime rates; terrorism; little private investor confidence; declining agricultural production and prices; poor access to quality health services and education; crumbling infrastructure; droughts and floods; the HIV/AIDS epidemic; and increasing malaria epidemics. Rural districts have seen the greatest declines. **In 2003, the Human Development Index ranking put Kenya at 146 out of 175 countries.**

4. **Taxes collected amount to approximately \$250 million while government spending is close to \$1 billion.** One third of the expenditure goes to the social sector, with far lower proportions going to the military than in neighbouring Uganda and United Republic of Tanzania. In the absence of support from the Bretton Woods institutions, the gap in the budget is filled through borrowing from domestic banks at commercial rates. The gap would be larger were it not for efforts to contain government spending on social services by allowing services to become increasingly market-driven. The result is less access to health care, education and other services for poor people, especially in arid areas. The way forward lies in more efficient and equitable services; the elimination of corruption, leading to an expanding economy; higher wages; and more tax revenue.

5. A serious effort to implement free primary education, as stipulated in the Children Act, was the first policy shift of the new Government, triggered in part by the advocacy on this issue carried out under the current programme. The quality of Kenya's primary education system has been in decline for over 10 years, and in some parts of the country - the arid areas - enrolment rates are very poor; boys in the north-east province are much less likely to enroll than in many other less developed countries. National enrolments increased from 5.8 million in 2002 to at least 7 million in early 2003. The greatest barrier to the enjoyment of the right to an education was charges to parents. Other important factors resulting in primary school completion and transition rates below 50 per cent include: inequity of access, especially in arid areas; high wastage rates due to drop outs and low transition; problems of quality and relevance of the curriculum; unavailability of teaching/learning materials; and a disenchanting teacher cadre.

6. Early 2003 saw renewed efforts by the Government to focus on the rights of street children. Many former street children, a phenomenon fuelled by HIV/AIDS, live in **municipality social centres** and privately run orphanages. Notable efforts also exist to keep children orphaned by HIV/AIDS in community care. There are nearly 2 million working children, the majority of whom work on family farms. Until the new drive for free education, about 1 million working children did not attend school. The extent to which working children are still unable to have access to school because they have to work to survive is unknown. Hazardous child labour, such as involvement in child prostitution and trafficking, exists on a small scale. Female genital cutting, an illegal practice, is widespread, including phallic circumcision, especially in arid areas. Cases of rebellion against the practice by groups of young girls who are becoming aware of their rights and the law are increasing.

7. The nutritional status of children has deteriorated over the past 20 years. One third of children under age five are stunted. The under-five mortality rate stands at 122 per 1,000 live births and has increased slightly over the last 10 years; the highest rates reliably recorded, 250 per 1,000 live births, occur in the Embakasi area of Nairobi. The rate of exclusive breastfeeding is 16 per cent. Early childhood care (ECC) practices are weak in many parts of the country, particularly where HIV/AIDS has hit hardest. If malnutrition was reduced by one half between 2000 and 2010, the

lives of some 70,000 children would be saved **per year**. Rates of malnutrition in the north of Kenya were likely kept at one half of the levels they would otherwise have reached in the course of the 2000-2002 drought relief programme.

8. Twenty-five per cent of Kenyans have access to health facilities within eight kilometres of their homes. Health expenditures in rural areas account for 30 per cent of government spending on health, while in urban areas (where only 20 per cent live) they account for 70 per cent. One in 33,000 Kenyans living in rural areas is a practicing medical doctor compared to 1 in 1,700 urbanites. Non-government entities provide almost one half of the medical services in Kenya. Faith-based organizations are very important in pastoral areas. Three quarters of children receive complete immunization. Less than one half of children with respiratory infections receive treatment from appropriate providers.

9. Malaria is the highest direct cause of death and disease among Kenya's children and women, causing an estimated 26,000 deaths every year, followed by respiratory infections. Approximately 20 million people live in malaria zones. In the western highlands, epidemic malaria has been increasing in frequency and severity since the 1980s, leading to emergency measures to contain outbreaks. Malaria is the main cause of severe anaemia in pregnant women and, thus, a major contributor to maternal mortality in a country where access to quality emergency obstetric care is rare outside of major urban areas.

Key results and lessons learned from previous cooperation, 1999-2003

Key results achieved

10. The programme of cooperation aims to follow a human-rights based approach to programming using a combination of advocacy, capacity-building and service delivery as implementation strategies. While the programme strategy for this period assumed that most implementation would take place through the Government, problems with liquidating cash assistance to Government allowed government implementation to start only in 2002.

11. Responses to HIV/AIDS are mainstreamed throughout all the programmes. UNICEF was a partner in developing the national strategic plan of the National AIDS Control Council (NACC). It supports implementation in partnership with the United Nations Development Group. A lead was taken in developing strategies for preventing mother-to-child transmission (MTCT) of HIV. National infant and child feeding guidelines and the Kenya code on marketing breastmilk substitutes have been revised. A pilot in three districts linking community mobilization for continued breastfeeding, maternal health and safe motherhood, voluntary counseling and testing, and the provision of anti-retroviral drugs is growing into a national programme strongly supported by the United States Centers for Disease Control and Prevention (CDC) and the United States Agency for International Development (USAID). The school curriculum on life skills and HIV/AIDS for three age groups has been developed, as well as a girls' soccer league in one district. The programme was a major contributor to the development of guidelines for people looking after children orphaned by AIDS. UNICEF is helping to develop a national plan for over 1 million children orphaned by AIDS. Activities have included a study on the contribution of faith-based organizations, seminars with non-governmental organizations (NGOs) and the private sector, an evaluation of the management of privately owned orphanages, and lobbying of parliamentary candidates through the press, on billboards, and through radio and television. Three hundred

teachers were trained in participatory hygiene and sanitary transformation processes, and accompanied as they transformed hygiene standards in their communities. The focus was on high HIV prevalence areas and places where cholera outbreaks are common. In Nairobi slums, latrines were built, latrine exhausters purchased, water points installed, tractors bought for garbage removal and almost a kilometre of drains built based on community plans. The programme contributed to the development of a sanitation policy and to the Water Act, especially with regard to its application in rural areas.

12. Between 2000 and 2003, the programme's largest element comprised activities made possible by funding through the Consolidated Appeal Process (CAP) for emergency relief in response to the worst drought in 60 years, which affected over 4 million pastoralists. The USAID/Office of U.S. Foreign Disaster Assistance (OFDA), the Department for International Development (DfID) (United Kingdom), the European Union, the Governments of Japan and Norway, and several National Committees for UNICEF provided major funding. Working with the Office of the President, UNICEF provided a coordination service for NGOs in the nutrition and water sectors. Activities in education, a sector badly hit by the drought, did not take off due to a lack of response to this element of the CAP. Results from this programme were technical support to NGOs managing feeding centres for malnourished children and the provision of food supplements to more than 500,000 malnourished children. Levels of malnutrition were held constant, saving the lives of many children. The water programme rehabilitated or replaced more than 400 water points, benefiting over 500,000 people, and provided chlorine and jerry cans to communities affected by floods.

13. The education programme, in partnership with the water and sanitation programme and with support notably from Japan, New Zealand, Norway and Sweden, worked in 16 arid districts to increase enrolment and achievement. District and school management capacity and community mobilization have been the key focus. So far, boarding houses for girls, in areas where a World Food Programme (WFP) school feeding programme is also active, have been supplied with over 1,000 beds and sheets, and over 1,500 bednets and mattresses. Teachers and school inspectors received vehicles, motorbikes and almost 250 bicycles. Over 10,000 textbooks and exercise books were supplied, 250 latrines for girls were built and over 80 water points were rehabilitated or newly completed. Responding to the post-election positive education emergency, 5,000 teachers were trained to maintain child-friendly stimulating classrooms for grades one, two and three with local materials at a cost of \$25 per classroom. Over 700 schools were supplied with a basic package of teaching, learning and recreation materials.

14. Results in the health sector include emergency obstetric care services under development in North-Eastern and Nyanza provinces, with a baseline survey in three districts, and the training of district health teams and community sensitization in two districts. The programme is now upgrading two district hospitals to be fully comprehensive and six health centres into basic emergency obstetric care facilities. Responding to emergencies, the malaria programme supplied free of charge over 200,000 bednets to pregnant mothers and infants through antenatal clinics. Through the expanded programme on immunization (EPI), UNICEF has supplied almost 15 million doses of measles vaccines and one-shot syringes, over 2 million doses of polio vaccine and almost 500,000 doses of tetanus toxoid vaccine; new vaccines have also been introduced through the Global Alliance for Vaccines and Immunization initiative. Through funding from the United Nations Foundation, American Red Cross and the Government of Canada, UNICEF and the World Health Organization (WHO) assisted the 2002 national measles immunization campaign, which reached

13.5 million children aged 9 months to 15 years at less than \$0.9 per child. The campaign also provided all children under five years of age with vitamin A. Contributions were made towards overall system support by rehabilitating elements of the cold chain, building several district hospital incinerators, and improving reporting from district to national level to 100 per cent in all districts.

15. In nutrition, a national survey on micronutrient deficiencies was conducted with funding from the Micronutrient Initiative. The food industry (salt, sugar, cooking fats) is now sensitized. Kenyans are now in the top echelon with respect to the consumption of iodized salt, and preparations are under way for triple fortification salt (with iron, iodine and vitamin A) and possible fortification of sugar with vitamin A. CARE baseline surveys took place in several districts, and guidelines focusing on 16 family practices aimed at Kenyans aged 9 months to 8 years were adopted by several NGOs. A contribution was made towards strengthening existing ECC programmes through community-based approaches, including a special focus on Muslim communities in 13 districts where 500 teachers were trained and centres were supplied with mats and appropriate furniture for young children.

16. In policy development, partnerships and participation, the programme played a key role in the 10-year lead-up to enactment of the Children Act in 2001. For children in need of special protection, through paralegal training, all children officers in the country are now sensitized or trained in the Act, the Convention on the Rights of the Child, International Labour Organization Conventions, the African Charter and other legal instruments dealing with children. It helped to form a National Committee on the Convention on the Rights of the Child for monitoring implementation of the Convention and is now working on the formation of the National Council for Children's Services (NCCS). In support of the United Nations General Assembly Special Session on Children, in 2002, over 650,000 'Say Yes for Children' pledge sheets were collected from all parts of the country. In 2000, UNICEF led the preparation of the Common Country Assessment (CCA), carried out a multiple indicator cluster survey (MICS) and is a core supporter of the 2003 Kenya Demographic and Health Survey (DHS). In collaboration with United Nations Development Assistance Framework (UNDAF) partners, capacity is now being built in the use of Ken Info at the Central Bureau of Statistics and in selected districts. Support to national efforts in the collection of vital statistics continued with the supply of computers and training of over 350 civil registration agents at the community level in several districts, resulting in the registration of 500,000 more births than would otherwise have been the case.

Lessons learned

17. One of the key lessons learned in the mid-term review (MTR) was that not enough truly convergent programming was taking place between sectors. The originally planned geographic scope had been too wide. The programme is now focusing on only two districts and the low-income areas of Nairobi in building community and district capacities in a convergent way for all priority areas of the medium-term strategic plan (MTSP), **although non-converged programmes are to be found nationwide. In the convergent areas,** baseline surveys have been conducted, district and community work plans have been developed, and implementation has begun. District offices are being computerized. The challenges are greatest in Nairobi, where coordination between city council and provincial administration and service-providing NGOs are weak.

The country programme, 2004-2008

Summary budget table

	<i>(In thousands of United States dollars)</i>		
<i>Programme</i>	<i>Regular Resources</i>	<i>Other Resources</i>	<i>Total</i>
Child Protection	1 800	6 000	7 800
Education and Youth	2 909	6 500	9 409
Health	2 909	4 960	7 869
Nutrition	2 169	4 900	7 069
Water and sanitation	2 415	6 500	8 915
Communications, partnerships and participation	2 909	2 100	5 109
Strategic planning, monitoring and evaluation	3 377	1 540	4 917
Cross-sectoral costs	6 171	-	6 171
Total	24 659	32 500	57 159

Preparation process

18. Preparation started in 2001 with the CCA, the MTR of the current programme and the preparation of the 2004-2008 UNDAF. A Steering Committee, comprised of representatives of the Ministry of Planning and National Development, UNICEF and NCCS, was formed in 2003 to guide the preparation. The exercise began with consultations with current partners, several of which were structured around organizational priorities involving NGOs and government departments and the business sector. There have also been consultations with children and youth, bilateral development partners and post-UNDAF consultations with United Nations partners. The discussions have been informed by an update of the situation of children and women and by evaluations of key programmes such as the African Girls Education Project that operates in north-eastern province and districts in Eastern and Rift Valley provinces.

19. UNICEF Kenya analyses the situation of children and women based on human rights principles. First, the disparities in progress, or the lack thereof, towards the realization of a set of rights were outlined; and their immediate, underlying and basic causes were noted. Second, the pattern of theoretical responsibility, or duties, from minister down to district government officers and the community level for coordinating progress towards the realization of the right or a cluster of rights was mapped out. Third, the capacity gaps that hinder fulfilment of the duty at all levels were analysed in terms of the extent to which a feeling of responsibility exists, authority to act is granted and resources are available. Fourth, the actions other development partners are taking to fill those capacity gaps were observed as a preamble to determining possible actions that UNICEF could take, divided into support for service delivery, building of capacity or advocacy. The views of children and youth were sought on the possible short-, medium- and long-term solutions to the issues. This analysis forms the preliminary work that has determined the proposed programme.

Goals, key results and strategies

20. The 2004-2008 programme will contribute to the realization of the rights of children and women nationwide in all the MTSP priority areas through policy support based on lessons learned from implementation of interventions, and through a combination of capacity-building and support

for service delivery at district and community levels. Activities will be determined through the application of a human rights approach to programming and community capacity development, and the commitment to respond quickly to humanitarian emergencies.

21. At least 60 per cent of all resources will be directed towards **district- and community-based action**, including one half of the regular resources allocation aimed at funding the HIV/AIDS response in the areas of orphans, prevention of mother-to-child transmission (PMTCT), youth and HIV/AIDS and care for people living with AIDS. The overall desired result will be to develop a movement for children in approximately 15 districts under the guidance of the district development committees, so that good progress is being made for full implementation of the Children Act. A key element of this focus will be efforts to establish safety nets for particularly vulnerable children on a co-financing basis. Lessons learned from this effort will be fed back for policy dialogue at the national level for better application of the Act nationwide. A start-up phase is expected to take from 6 to 12 months in each district, an expansion phase one to three years, and a maintenance phase where demonstrated improvements are taking place district-wide based on a wide coalition of partners being sustained thereafter.

22. The programme will continue to coordinate nutrition and water-related drought relief and rehabilitation in arid districts. In the same areas, a major contribution will be made towards improved ECC, increasing primary-school graduation rates, reducing rates of female genital cutting and maternal mortality ratios, the latter starting in North-East province. The Meru area is particularly hard hit by HIV/AIDS yet there are few international partners helping local authorities fight the epidemic compared to other parts of Kenya. Here the programme will support the Government in supporting service-delivery-oriented community organizations that focus on children orphaned by HIV/AIDS.

Relationship to national priorities and UNDAF

23. This country programme is derived from the UNDAF 2004-2008, which is itself based on national priorities, including the poverty reduction strategic framework and the Government's socio-economic recovery plan. The programme will contribute mainly to human resources development, HIV/AIDS and malaria, governance and rights, and strengthening local and national systems for emergency preparedness and response.

Relationship to international priorities

24. The Millennium Development Goals, "A World Fit for Children" and the UNICEF organizational priorities informed the UNDAF.

Programme components

25. **Child protection and HIV/AIDS:** The overall goal of the programme is to contribute to the protection of children in need of special protection from violence, abuse, exploitation, discrimination and HIV/AIDS through the following projects: (a) children orphaned by AIDS; (b) juvenile justice system; (c) coordination and networking; and (d) gender violence, exploitation and discrimination.

26. Working through the district development committees, the programme aims to develop a network of community committees that will identify and support the most vulnerable children. It

will support the communities on a co-financing basis to help those children realize their rights to services such as health and education. Capacity will be built to carrying out surveillance and rescue, protection, care and support, rehabilitation and integration. The programme will target street children, those in child labour, children with disabilities, displaced children including refugees, orphans and children in the juvenile justice system. Partnerships with communities, households, NGOs, community- and faith-based organizations, the private sector, children and government officials around child protection issues, including local resource mobilization, will be strengthened. These interventions will influence the review and formulation of relevant policies.

27. **Education, youth and HIV/AIDS:** This programme focuses on areas with the poorest primary education performance, **especially for girls**, to develop school clusters, with a special emphasis on stimulating classrooms at sustainable costs and mobilizing communities to send their children to school **in arid districts. In areas with a large population of school-age children, especially** in urban areas, a second chance education programme will be supported for working youth who did not complete primary school, street children who cannot immediately rejoin the formal stream **and child labourers**. Other development partners supporting the Ministry of Education, Science and Technology are notably DfID, the Swedish International Development Authority (SIDA) and the World Bank, all of which are partnering to make textbooks more accessible nationwide, and WFP, which will be working with UNICEF in the school feeding programme. The youth and HIV/AIDS component aims to expand the use of the livelihoods and HIV/AIDS curriculum/**life skills** developed under current cooperation, and to work with youth clubs to expand self-esteem enhancing activities such as women's soccer leagues.

28. **Health:** This programme includes **district** health systems support, EPI, emergency obstetric care, malaria and the prevention of MTCT of HIV. It will contribute to partnerships, notably with SIDA, the Danish International Development Agency, DfID, USAID and the World Bank to build health systems. **The particular contribution of UNICEF will be focused in Northern Districts, Nairobi, coastal areas and in the** highland epidemic malaria zones, and nationwide for EPI. MMR will be reduced **starting in north-east province** through mobilizing communities and supporting emergency obstetric care services. In partnership with DfID and WHO, efforts to increase the use of impregnated bednets will continue, with UNICEF focusing on 10 highland districts and in north-east province. In the area of the prevention of MTCT, **the programme will focus on northern districts in partnership with USAID.**

29. **Nutrition:** This programme will focus on national nutrition policy development and implementation, improving infant and child feeding and psychosocial care, combating micronutrient malnutrition, care for people affected by HIV/AIDS and strengthening emergency preparedness and response in drought- affected areas. The emergency component will build government capacity to coordinate humanitarian responses, strengthen nutrition information systems and oversee quality-feeding centres managed by NGOs. The micronutrient project aims to employ multi-faceted strategies to reduce vitamin A and iron deficiency and to sustain the elimination of iodine deficiency disorders. Stronger service delivery through the EPI system, encouraging greater use of iron/folate supplements as well as multi-micronutrient fortification of food products is envisaged. Proper child feeding will be encouraged through behaviour change communication and capacity development of key district personnel. Key partners include FAO, WFP and WHO.

30. **Water and sanitation:** This programme will coordinate the water sector in drought emergency areas and in areas where cholera outbreaks and flooding are problems. Nationwide, it will contribute to implementation of the sector reforms, particularly in rural areas, focusing on

learning districts. The Ministry of Water will be supported in its efforts to upgrade water and sanitation in schools, health centres, and hospitals, especially in arid districts and other areas with marked disparities and needs. This will be done in coordination with the PMTCT and EmOC programmes.

31. **Communications, partnerships and participation:** This programme works in tandem with the strategic planning, monitoring and evaluation programme to communicate successful efforts to fully realize children's rights to a wide group of partners so as to increase the resource base for child rights programming; improve policies for children and accelerate their implementation by duty bearers. The programme will coordinate children's and young people's participation in advocacy. It will also coordinate intersectoral community mobilization strategies using participatory methodologies to increase public awareness of child protection issues and encourage appropriate health-seeking behaviours. In learning districts, this programme will manage the development and response to community action plans on implementation of the Children Act.

32. **Strategic planning, monitoring and evaluation:** This programme will build the institutional capacity of key partners to monitor and report on the implementation of the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination against Women and the Children Act using a human rights approach. Policy makers and stakeholders will be sensitized on the need for legal reform, policies, laws and regulations aimed at influencing the allocation of resources in favour of basic social services. The programme will coordinate integrated monitoring, evaluation and research activities of the entire country programme including an intensive evaluation focus on interventions at community level. Comprehensive data will be generated to close information gaps on children and women leading to the development and promotion of effective policies for children. This data will be used to advocate for the development of new policies and the strengthening of existing policies related to the survival, development, protection and participation of children and women. In collaboration with key United Nations and bilateral partners, support will be provided to the Central Bureau of Statistics in the use of *ChildInfo* to track progress in the MDGs and national socio-economic development targets. Complementary support will be provided to the collection, collation and effective use of civil registration data. The programme will build district capacity in participatory programme planning, implementation, management, monitoring and evaluation.

33. **Cross-sectoral costs.** This component will cover recurrent costs, including office rent, utility costs and costs of security in United Nations security phase three areas, and the salaries of administration and finance, and supply procurement staff. Procurement services are projected to be an area of growth in the programme.

Major partnerships

34. The 1999-2003 programme has many partners, with an expectation for expansion. The programme will be managed jointly by the Government of Kenya and UNICEF through a Steering Committee co-chaired by the UNICEF representative and the Permanent Secretary of the Ministry of Planning and National Development. Membership comprises permanent secretaries from ministries, currently eight in number, that work closely with the programme. Daily operations are in the hands of an interministerial technical committee of UNICEF and government officers managing programme components. Partnerships beyond the Government include the business sector, notably via the *Watoto Kwanza* Trust. International and national NGOs and faith-based organizations are

also close partners, notably, Action Against Hunger, ANPPCAN (African Network for the Prevention and Protection against Child Abuse and Neglect), Catholic Diocese of Lodwar, Catholic Diocese of Marsabit, Childlife Trust, FAWE (Forum for African Women Educationalists), International Medical Corp, KAACR (Kenya Alliance for the Advancement of Children's Rights), Kenya Scouts Association, OXFAM-Quebec, *Maendeleo ya Wanawake*, National Council of Churches, *Nyumbani*, Save the Children Alliance, TAPWAC, the Undugu Society, Women Concern and World Vision. Bilateral development partners which have provided major other resources funding to the 1999-2003 programme include: the European Union, DfID, OFDA, the Governments of Japan and the Netherlands, the Canadian International Development Agency, the Norwegian Embassy, SIDA, the United Nations Foundation and the CDC. Among multilateral agencies, the programme will cooperate especially with the International Fund for Agricultural Development, the Joint United Nations Programme on HIV/AIDS, the United Nations Development Programme, the United Nations Development Fund for Women, the United Nations Population Fund, UNOPS, WFP, WHO and the World Bank. Partnerships have been expanding with a growing number of community-based organizations working mainly in support of service delivery for children orphaned by HIV/AIDS.

Monitoring, evaluation and programme management

35. Results will be measured using process indicators aimed at evaluating the programme strategies adopted and outcome indicators, including country-specific Millennium Development Goals and poverty reduction strategy indicators. Monitoring, research and evaluation activities for the country programme will be coordinated through an Integrated Monitoring and Evaluation Plan. The interministerial technical committee for the programme under the Ministry of Planning and the Steering Committee will undertake monitoring of the country programme through a combination of direct oversight of funded activities and formal review. This will involve the development and standardization of formats and tools to facilitate regular monitoring and evaluation of sectoral projects using the African Evaluation Standards. Simple monitoring tools at the community level will facilitate community/district interaction. Major evaluative activities include learning achievement tests in schools, maternal death audits, and baseline and impact measurement surveys in “**child-friendly districts**”. A second MICS will be conducted in 2005/2006 tracking changes since the 2003 Kenya Demographic and Health Survey, **while technical and limited financial contributions will be provided to other national surveys (e.g., the 2004 Integrated Household Budget Survey and the 2006 Welfare Monitoring Survey)**. An MTR will be conducted jointly with the Government, other United Nations agencies and key development partners in 2006.

Summary Results Matrix

UNICEF MTSP Priority Area	Key results expected in this priority area	Key Progress Indicators	Means of Verification	Major Partners, Partnership Frameworks and Co-operation Programmes	The expected key results in this Priority Area will contribute to:
Girls' Education	<p>Increased access to and completion of quality early childhood education, basic education and complementary, alternative education with special focus on girls.</p> <p>Improved government and community capacity to deliver quality free primary education.</p>	<p>NER by gender GER by gender Drop-out rates by gender Completion rates by gender</p>	<p>School, zone, division and district enrolment data.</p> <p>School, zone, division and district data on repetition, dropout and completion.</p>	<p>MOEST, MOHA, MOL, MOLG, MOW, MOH, OP (Government programme)</p> <p>WB and DfiD (Textbook supply in all schools) and training of SMCs on financial management</p> <p>Action AID and Aga Khan (ECD)</p> <p>Aga Khan and DfiD (Teacher Improvement Programme).</p> <p>FAWE (Support to Girls Education)</p>	<p>UNDAF expected outcome: Increased access to use of basic social services</p> <p>EFA goals: Eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015 with a focus on ensuring girls' full and equal access.</p> <p>MTSP goals: By 2005 countries with a girls' NER of <85% in 2000 have policies & procedures & practices that reduce the number of out of school girls by 30%.</p> <p>WFFC goal: Providing quality education and combating HIV/AIDS; Providing Quality Education.</p> <p>MDGs: Achieve universal primary education; Promote gender equality and empower women</p>
IECD	<p>Increased access to quality IECD services and essential commodities at household, community and at institutional level</p>	<p>% of population accessing ECD facilities</p> <p>IMR, U5MR, MMR</p>	<p>National Surveys (e.g MICS and KDHS) GOK reports</p>	<p>DHMT and health officials district level;</p> <p>NGOs (local and international) and CBOs – service delivery, Ministry of Health and the inter-ministerial technical team (IMTC) – overall management of programme components ,DFID, USAID, JICA, WHO, DANIDA, and Rotary International, OFDA, ECHO, CIDA</p>	<p>UNDAF: Increased access to basic social services.</p> <p>EFA: ..Expanding & improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children...</p> <p>MTSP: Support the development of comprehensive ECD policies...</p> <p>WFFC: Promoting healthy lives, Providing Quality Education</p> <p>MDGs: Achieve universal primary education;</p>

					Reduce child Mortality, Eradicate extreme poverty and hunger.
Child Protection	Enhanced capacities of key national and local institutions for implementation of Children's Act	Key statutes and policies related to children reviewed and reformed, new laws enacted, to bring them all into conformity with the provisions of the new constitution and the Children's Act to address violence and abuse, exploitation and discrimination	GOK and counterpart reports	<p>Government Ministries/Depts: Health, Education, Home Affairs (National Council for Children's Services and the Children's Department), Planning and National Development, and the Judiciary</p> <p>Key NGOs (KAACR, ActionAid and others)</p> <p>Donors and UN agencies</p>	<p>UNDAF: Enhanced capacities of key national and local institutions for improved governance</p> <p>MTSP: To ensure the respect and fulfillment of the children's right by governments, persons in authority and others with influence or control over children's lives</p> <p>WFFC: Protecting against abuse, exploitation and violence</p> <p>MDGS: Protecting the vulnerable (Millennium Summit Declaration, section VI)</p>
Immunisation Plus	<p>Increased access to sustainable quality immunization services</p> <p>Increased coverage of fully immunized children <1 year in all districts achieved</p>	<p>National immunisation coverage by antigen</p> <p>Uninterrupted supply of vaccines and Vitamin A for regular services, accelerated disease control activities and outbreak response</p> <p>Number of disease cases reported Number of children with access to immunisation Vitamin A, and ITNs</p>	<p>National Surveys</p> <p>Facility assessments</p> <p>MOH reports</p>	<p>DHMT and health officials district level; NGOs (local and international) and CBOs – service delivery, Ministry of Health and the inter-ministerial technical team (IMTC) – overall management of programme components, DFID, USAID, JICA, WHO, DANIDA, and Rotary International, OFDA, ECHO, CIDA</p>	<p>UNDAF: Increased access to basic social services</p> <p>EFA...Expanding & improving comprehensive early childhood care and education, especially for the most vulnerable and disadvantaged children...</p> <p>MTSP: Ensure full immunization of children <1year at 90% nationally with 80% coverage in each district...</p> <p>WFFC: Promoting healthy lives</p> <p>MDGS: Goal 1: Eradicate extreme poverty and hunger, Goal 4: Reduce child mortality Goal 5: Improve maternal health, Goal 6: Combat HIV/AIDS, malaria and other diseases.</p>

Fighting HIV and AIDS	<p>Increased access to recommended core interventions in PMTCT</p> <p>Reduction of MTCT of HIV/AIDS from 10% -5% by 2008</p> <p>Reduce HIV transmission amongst young people</p>	<p>% of women receiving the recommended PMTCT services</p>	<p>MOH and Project Reports</p>	<p>Ministry OF Health, NASCOP, NACC, UNAIDS</p>	<p>UNDAF: Reduce further the spread of HIV/AIDS and improve the quality of life of those affected by HIV/AIDS; Increased access to basic social services.</p> <p>EFA: ...ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning and life skills programmes...</p> <p>MTSP: By 2005 reduce the proportion of infants infected with HIV by 20% and by 50% by 2010...</p> <p>WFFC: Promoting healthy lives, Combating HIV/AIDS</p> <p>MDGS: Combat HIV/AIDS, malaria and other diseases</p>
Malaria	<p>Improved preventative and curative child health services including malaria control</p> <p>Increased knowledge of the causes in selected districts of the causes, treatment and prevention of malaria</p>	<p>% of population seeking care and receiving treatment for malaria</p> <p>Reported malaria cases and deaths in U5s and pregnant women</p> <p>% of households practicing IMCI activities</p> <p>% of the population taking appropriate preventive measures and can describe the causes and treatment of malaria.</p>	<p>National Surveys Facility Assessments</p>	<p>Government: Ministry of Health, Education, Home Affairs, Planning and National Development</p> <p>Donors and UN agencies</p> <p>NGOs e.g Aga Khan Foundation, Care Kenya, Plan International, Action Aid,</p>	<p>UNDAF: Outcome 5: Morbidity and mortality resulting from malaria reduced in 25 districts as part of the national efforts.</p> <p>WFFC: Promoting healthy lives.</p> <p>MDGS: Goal 4: Reduce child mortality Goal 6: Combat HIV/AIDS, malaria and other diseases</p>