Adolescent Sexual & Reproductive Health

DEVELOPMENT IMPACT BOND

Final Report for the Mid-Term Review of the

Adolescent Sexual Reproductive Health Development Impact Bond (ASRH-DIB)

UN Joint Program

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List of Abbreviations

ART:	Antiretroviral Therapy
ASRH:	Adolescent Sexual and Reproductive Health
CASCO:	County AIDS & STIs Coordinator
CAWP:	County Annual Work Plans
CEC:	County Executive Committee Member
CIDP:	County Integrated Development Plans
CIFF:	Children's Investment Fund Foundation
CRHC:	County Reproductive Health Coordinators
CSOs:	Civil Society Organizations
DIB:	Development Impact Bond
FGDs:	Focus Group Discussions
GBV:	Gender-based Violence
JP:	Joint Program
KHIS:	Kenya Health Information System
KIIs:	Key Informant Interviews
LNOB:	Leaving No One Behind
MoU:	Memorandum of Understanding
MTR:	Mid-Term Review
RMNCAH:	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDG Fund:	Sustainable Development Goals Fund
SDG PP:	Sustainable Development Goals Partnership Platform
SDG:	Sustainable Development Goals
SMART:	Specific, Measurable, Attainable, Relevant, Time-bound
SRH:	Sexual and Reproductive Health
UHC:	Universal Health Coverage
UNAIDS:	Joint United Nations Program on HIV/AIDS
UNEG:	United Nations Evaluation Group
UNFPA:	United Nations Population Fund
UNRCO:	United Nations Resident Coordinator's Office
UNSDCF:	United Nations Sustainable Development Cooperation Framework
WHO:	World Health Organization

Acknowledgements

The Midterm Review (MTR) of the Adolescent Sexual and Reproductive Health Development Impact Bond (ASRH-DIB) would not have been possible without the invaluable contributions and support of a wide range of stakeholders.

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We commend our implementing partner, Tiko Africa for their innovation and dedication in rolling out the DIB model and supporting healthcare providers, mobilizers, and communities to deliver adolescent-centered SRH and HIV services.

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Finally, we recognize the important role of the Reference Group team in guiding the review process. Their thoughtful engagement in reviewing the inception report, providing technical feedback throughout the MTR, and contributing to both the draft and final reports, thereby significantly strengthening the quality and relevance of this review.

To all who contributed time, expertise, and insights, we extend our heartfelt thanks.

Executive Summary of the MTR

Program Background

The Adolescent Sexual and Reproductive Health Development Impact Bond (ASRH-DIB) was designed and implemented to address the dual challenge of untimed pregnancies and new HIV infections among adolescent girls aged 15-19 years in ten high-burden priority counties in Kenya, namely: Bungoma, Busia, Homabay, Kakamega, Kisii, Kisumu, Mombasa, Migori, Nairobi and Nyamira. The program is implemented by a consortium including UNFPA, WHO, UNAIDS, SDGPP, Tiko and the Government of Kenya (national and county). The two-year pay-for-success initiative aims to reach over 500,000 adolescent girls aged 15–19 years with SRH and HIV services. The program builds on a successful DIB model previously implemented by CIFF, FCDO, and Tiko between 2020 and 2022.The design of the program started in 2020 and was approved for funding by the Joint SDG Fund in January 2022, receiving $7 million as catalytic funding towards improving adolescent SRH and HIV outcomes in Kenya. In 2023, the program received an additional $5 million from CIFF, with implementation of the program starting in July 2023.

The ASRH DIB targets three interrelated challenges: (1) identifying adolescents with undiagnosed HIV and linking them to care and treatment, (2) ensuring continuity of HIV treatment and achieving viral suppression among adolescents on antiretroviral therapy, and (3) addressing the unmet need for contraception and unintended pregnancies among adolescent girls. To do this, the program employs a digital platform with real-time data capabilities, enabling girls to select their preferred mode and location for accessing services. For those without mobile phones, access is facilitated via a smart card system. Services are delivered through a broad network of public and private facilities, including pharmacies, ensuring both quality and variety in service provision. The short-term outcomes of the program include: (i) increased agency among adolescent girls to exercise their SRH rights, (ii) increased utilization of quality SRH and HIV services within the public sector, and (iii) increased availability of public and private resources for adolescent SRH and HIV services in Kenya. Long-term outcomes are aligned with key SDG targets and include reductions in new HIV infections, AIDS-related deaths, and adolescent pregnancies.

Purpose and Scope of the MTR

The purpose of the mid-term review (MTR) was to: assess progress towards achievement of the ASRH-DIB objectives and key results, assess early signs of programmatic success or failure, identify necessary changes to be made (if any) in order to ensure that the program is on-track to achieve its intended results, and review the strategy of the program and risks to sustainability. The scope of the MTR covered five criteria as specified in the terms of reference. These included: design, progress/results to date, management efficiency, risk management, and sustainability/exit strategy.

Approach and Methods of the MTR

The MTR adopted a mixed-methods approach, combining both quantitative and qualitative data to ensure a comprehensive understanding of the program's performance. Purposive sampling was used due to its suitability for qualitative reviews that seek depth, relevance, and contextual insight over statistical generalizability. Data collection tools were prepared to elicit information from participants based on the scope of the MTR, and included: a desk review checklist, key informant interviews (KIIs) and focus group discussions (FGDs) guides. KIIs were held with representatives of funders (SDG Fund), participating UN agencies (UNFPA, WHO, UNAIDS, SDGPP), implementing partner (Tiko), national government agencies (RMNCAH, NASCOP and NSDCC), county governments (CRHCs, CASCOs and CAYP-Focal Persons), healthcare providers from pharmacies, private and public healthcare facilities, and mobilizers from CBOs. FGDs were held with adolescent girls aged 15-19 years to gather lived experiences and perceptions on program relevance, access, and impact. Quantitative data from program monitoring systems such as biannual evaluation reports, were analyzed using descriptive statistics such as frequencies, percentages, and trends over time. Qualitative data from KIIs and FGDs were analyzed thematically using a deductive-inductive coding framework aligned with the scope of the MTR. Data triangulation was done to enhance the validity, reliability, and depth of findings by systematically integrating evidence from multiple sources: KIIs, FGDs, desk review documents, and program monitoring data. Ethical standards for research involving human participants were followed as per the United Nations Evaluation Group (UNEG) Ethical Guidelines.

Findings and Ratings Summary of the MTR

The findings and ratings of the MTR based on the five review criteria (design, progress/results to date, management efficiency, risk management, and sustainability/exit strategy) are presented. A five-point scale rating was used as below:

1 = Highly satisfactory: Strong performance, exceeding expectations.
2 = Satisfactory: Adequate performance, objectives likely to be achieved.
3 = Moderately Satisfactory: Minor shortcomings, but overall on track.
4 = Unsatisfactory: Major shortcomings, unlikely to meet objectives unless addressed.
5 = Highly Unsatisfactory: Severe shortcomings, objectives will not be met.

These ratings were then mapped onto the traffic light system: 1-2 = Green: On track/Highly satisfactory; 3 = Yellow: Moderately satisfactory/Some concerns 3; and 4-5 = Red: Off track/Unsatisfactory.

Criterion	Rating	Color Code	Rationale and Achievement Description
Design	2		The "Pay-for-Success" financing mechanism incentivized performance, encouraged adaptive management, and promoted accountability across all implementing partners. The program made measurable contributions to SDGs 3 (good health and well-being), 5 (gender equality) and 17 (partnerships for the goals), was well-aligned with Kenya's UNSDCF strategic priority 1 on people and peace, and the commitment to end the "Triple Threat". Notable exclusions (boys and men, younger adolescent girls 10-14 years, young women 20-24 years, and adolescents with hearing/speaking disabilities – due to the voice validation setting on the Tiko platform) need addressing to enhance inclusivity. There is also a need to broaden the service package to include GBV, STIs, cervical cancer prevention, provision of sanitary pads and mental health services. Finally, Tiko miles need adjustment, harmonization and standardization for various groups (adolescent girls, providers and facilities) across the service chain.
Progress/Results	1		The majority of the outcome indicators have been met and surpassed well ahead of the project timeline. This success can be attributed to multi-sectoral collaboration, inclusion of public health facilities, capacity building for healthcare providers, robust data and monitoring systems, community mobilization and peer engagement, financial incentives across the service chain, and flexibility of the program model. The program has shown that performance-based financing can successfully drive outcomes in ASRH/HIV services, making it a potential model for other health programs, as well as programs in other sectors such as education, in Kenya. The program has also demonstrated potential for developmental impact in the counties where it has been implemented (for example by enhancing school retention for adolescent girls), and can be replicated to other counties in Kenya, and countries with similar contexts. Although counties do not directly co-finance the program, their in-kind contributions are substantial, including: administrative oversight for both public and private health facilities, procurement and distribution of SRH/HIV commodities, payment of salaries for healthcare providers in public health facilities, and integration of program-supported activities into their development and annual work plans. While not quantified during the MTR, these contributions significantly boosted program delivery and underscore the counties' commitment to ASRH/HIV services.
Management Efficiency	2		Overall, the management of the program was efficient, with a steering committee providing strategic guidance and a technical committee responsible for implementation. The UNRCO office provides strong high-level coordination, leading to effective program implementation by the UN Joint Team, Tiko, counties, health facilities and mobilizers. Decision-making is transparent and timeous, with clear reporting lines at different program levels. However, operational decisions, especially those linked to payment flows, face delays e.g. mobilizers in some counties reported delays in receiving their reimbursements. Lessons learned are well-documented and disseminated through review meetings minutes, joint field monitoring reports and annual progress reports. Policy briefs and publications in peer-reviewed journals are missing from the learning agenda, limiting the thought-leadership profile of the program. The program has a communications strategy that reflects the joint nature of the program, and focuses on advocacy, branding and audience-specific messaging. The program has leveraged high-profile national (e.g. Global Digital Health Forum 2024) and global (UNGA 2024 and 2024 Global AIDS update by UNAIDS) platforms to showcase its success. Nevertheless, gaps are noted in limited amplification of these high-profile and national events, reduced social media activity post-program launch, insufficient adolescent-led digital advocacy and storytelling, and learning agenda not being fully linked to the communications strategy.

Risk Management	3		The risks identified in the project document and annual reports such as commodity shortages and political opposition remain the most relevant threats to program success, with risk ratings generally aligned with the operational reality. Notwithstanding, some risk ratings may require updating. For contextual risks, COVID-19 restrictions may be less relevant in 2025, with frequent healthcare provider strikes and sporadic outbreaks of Mpox posing greater risks. Fraud and corruption risks were previously assessed as (Likely likelihood 4 * Minor impact 2 = 8), and may have been underestimated based on findings such as blacklisting of some health facilities following verification processes that uncovered falsification of data aimed at increasing claims for incentives, and lack of transparency in the way facility incentive program funds were utilized. Technology risks were rated as (Unlikely likelihood 2 * Major impact 4 = 8), and may also need upward revision, with feedback from healthcare providers revealing operational challenges that heighten these risks, including: internet connectivity gaps, challenges with voice validation on the Tiko platform, and weekend service access constraints. Other emerging risks include ambiguity in the legal and policy environment, as well as high staff turnover. Unintended positive effects of the program include: strengthened multi-sectoral collaborations, expanded uptake of SRH/HIV services beyond the target cohort, and enhanced capacity of healthcare providers in using digital health platforms. Unintended negative effects include: incidents of fraudulent activity, technology access barriers and service gaps resulting from high staff turnover.
Sustainability/Exit strategy	3		The likelihood of sustaining the program's financial instruments after completion is moderate. While all ten counties have committed to co-financing public sector delivery, these commitments are not matched by budgetary allocations. Sustained financing will depend heavily on National Treasury allocations to the counties. There is also the opportunity to include ASRH/HIV services in the SHA service package so that primary healthcare facilities receive reimbursements after providing these services. Some counties e.g. Bungoma have ring-fenced funds toward AYSRH and will continue to engage Tiko as an output co-payer using the DIB model. Three more counties are also designing strategies to continue providing ASRH services using a model similar to that of the DIB. Institutionally, there is demonstrable strong program ownership at the national, county, private sector and community levels. Looking forward, except for lack of incentives, program actions are likely to continue post-program. For instance, county governments have incorporated strategies such as mobilization to register community members with SHA, suggesting potential for continuity. Healthcare providers and mobilizers highlighted that acquired digital health skills are transferrable to other health initiatives such as those addressing mental health issues. Adolescent girls expressed that the peer-friendly and non-judgmental services should be sustained beyond the program. In closing, the program has not yet articulated a fully detailed exit strategy. While there is an intention to transition responsibilities to county governments, specific timelines, financing arrangements, and capacity-building milestones are still under development. County health officials have stressed the importance of early planning for the phase-out of external incentives, to avoid sudden service uptake declines. Noteworthy, Tiko continues to operate at scale in the implementation counties through other donors though the ideal long-term strategy is to have the counties co-finance ASRH programs.

Conclusion and Recommendations

The MTR demonstrated that the program is well-designed, delivering results beyond initial targets, and continues to present valuable lessons for health financing innovations in Kenya. The findings highlight both strong progress and persistent challenges, with clear implications for sustainability and scale-up.

Building on the findings of the MTR, targeted recommendations are made to strengthen the program across five key review criteria (design, progress/results to date, management efficiency, risk management, and sustainability/exit strategy)**.**

Together, they aim to enhance the inclusiveness and effectiveness of service delivery, optimize program management and communication, anticipate and mitigate risks, and secure long-term gains through strengthened systems and community ownership.

Design: Adopt alternative means to voice validation to include beneficiaries with hearing/speaking disabilities. One option is to incorporate finger-based scanners that do not store actual fingerprint images but instead convert them into irreversible, encrypted alphanumeric templates (hash codes). These templates cannot be used to reconstruct the fingerprint, thus meeting privacy and data protection standards as per the Kenyan law and global standards on data protection. For users uncomfortable with biometric data, strengthen provider capacity to use manual PIN or QR-code–based verification options which are part of the current model. Overall, clearly communicate privacy safeguards to build trust in the system, and train service providers on disability-inclusive service protocols.

Include adolescent girls aged 10 – 14 years and young women aged 20 -24 years: For adolescents aged 10-14 years, develop provide age-appropriate services that prioritize education, prevention, protection, and psychosocial support, without normalizing early sexual activity e.g. as guided by NASCOP's 'HIV Prevention and Treatment Package for Adolescents and Young People'. Additionally, extend program eligibility to cover young women aged 20–24 years, with services tailored to their life stage to ensure uninterrupted service use during high-risk years. Particularly, introduce the program in TVETs, colleges and university to serve adolescent girls and young women transitioning to adulthood.

Include adolescent boys and young men by integrating male-focused SRH/HIV education sessions into community outreach; providing adolescent-friendly services for boys and young men in both public and private facilities; designing couple-based or peer-to-peer interventions that promote shared responsibility in SRH and HIV prevention; and engaging male role models and community leaders to challenge harmful gender norms.

Broaden package of services to cover intersecting vulnerabilities and co-occurring conditions, including: GBV prevention, screening, response and referral mechanisms; STI screening, diagnosis, treatment, contact tracing and education; cervical cancer screening and strengthening promotion and delivery of the HPV vaccine; mental health services including screening, counselling, psychosocial support, and referral linkages.

Adjust, harmonize and standardize Tiko miles: For adolescent girls, increase from 40 to 80-100 miles per service, to enable girls to redeem pads consistently. For mobilizers, harmonize to 125 miles per effective referral, regardless of method, thus balancing program equity with digital adoption goals. For public healthcare providers, increase 20 miles to within the range of 50-75 miles per service, to balance provider effort with program sustainability. For private healthcare providers, introduce 50-75 miles per service to match what is proposed for public providers, to enhance equity, strengthen morale, and ensure quality service delivery and accountability across all types of facilities. For all in the Tiko miles chain, consider incremental adjustments, as well as strengthening other incentives such as recognition certificates and conference sponsorships.

Progress/results to date:

Support girls testing positive for HIV to ensure linkage to care and treatment by strengthening referral and linkage systems between private and public facilities, working with mobilizers and young peer providers as patient navigators to accompany girls to referral facilities, provide psychosocial support, and follow up on treatment initiation and adherence, and where possible, integrating service delivery by initiating ART directly at facilities providing HTS (including private facilities), to reduce the risk of drop-offs during referral. Additionally, strengthen adolescent-friendly ART services in public facilities, ensuring confidentiality, stigma-free care, and flexible hours (e.g., weekend or after-school access), and enhance data tracking to improve tracking within the Tiko platform to flag girls who test positive and follow their linkage to treatment, with feedback loops to providers and mobilizers to close gaps.

Management efficiency: Improve coordination by UNRCO office by expanding domestic resource mobilization efforts to include local private sector actors, philanthropic organizations, and high-net-worth individuals in Kenya; and developing tailored investment pitches demonstrating the program's return on investment in terms of social impact, economic benefits, and alignment with Kenya's UHC and "End the Triple Threat" agenda. Moreover, leverage the UNRCO's convening power to mediate and resolve operational issues, such as payment delays, by facilitating rapid decision-making between UN agencies, Tiko, government partners and providers.

For the learning agenda, develop a centralized knowledge repository accessible to all partners; produce regular learning briefs summarizing innovations, challenges, and scalable approaches; embed lesson-reflection sessions in quarterly review meetings, with structured follow-up to ensure that agreed improvements are implemented at county level; produce policy briefs to inform

scaling and replication of innovations; and publish peer-reviewed articles in scientific journals to increase program visibility in academia and research, and showcase the thought leadership of the program. To strengthen reporting by private facilities and pharmacies, provide training, clear reporting templates, mentorship and support supervision to providers, to ensure data on SRH/HIV services are properly captured and fed into the KHIS to inform reporting, planning and decision-making.

Regarding the communications strategy, reignite social media momentum by developing and maintaining a content calendar with monthly updates on program achievements, human-interest stories, and service uptake data; amplify high-profile engagements through pre-event teasers, live updates, and post-event summaries with photos, quotes, and key takeaways for circulation on social media, websites, and newsletters; empower county-level champions by equipping county governments, CBOs, mobilizers and adolescents with branded communications kits (templates, fact sheets, key messages) to facilitate localized storytelling; invite representations from county governments, CBOs, and youth ambassadors to co-present/co-host sessions at upcoming conferences like AVPA (November 2025, Nairobi); scale adolescent-led campaigns by supporting adolescent girls and peer educators to produce and post short videos, testimonials etc. on SRH/HIV topics under a recognizable campaign hashtag (e.g., #MyFutureMyChoice), and link the learning agenda to communications by publishing research briefs, case studies, and infographics from program data and presenting them at sector events such as upcoming Devolution Conference 2026.

Risk management: Update the risk management plan by revising outdated risks (e.g., COVID-19 restrictions) to reflect emerging threats such as health worker strikes and sporadic Mpox outbreaks; elevate risk ratings for fraud/corruption and technology-related barriers to align with field realities, and incorporate high staff turnover as a formal programmatic risk.

Strengthen fraud and corruption prevention by building on existing verification processes to flag anomalies in real time; instituting transparent and documented utilization of reimbursements at public facilities, through the leadership of county health management teams, with support from other program partners; providing targeted training on ethical claims processing for all newly on-boarded providers, and granting CHMTs relevant access to the Tiko data dashboard to enable them monitor progress in their counties, and institute corrective action where incidences of data falsification are suspected.

Address technology barriers proactively by utilizing part of the reimbursements in public health facilities to install and pay for stable internet to support provision of ASRH/HIV services; adopt alternative means of validation other than voice e.g. finger-based scanners that do not store raw fingerprint images but generate encrypted, irreversible alphanumeric templates, and automate weekend access for the Tiko platform to align with peak service demand from school-going girls, reducing reliance on cumbersome manual activation requests and authorizations.

Address legal and policy framework risks by continuing to leverage the 2010 Constitution as the supreme legal framework to guide service delivery; strengthening advocacy efforts with MoH, Parliament, and civil society to push for alignment of the 2022 National Reproductive Health Policy with constitutional guarantees and international human rights standards; engaging legal aid and human rights organizations to support providers and adolescents navigating policy-related barriers; and closely monitoring the High Court petition against the 2022 Policy outcome and adapting the program accordingly.

Mitigate high staff turnover by developing a rapid response onboarding toolkit (digital and in-person) to train incoming staff within 48 – 72 hours of transfer, and adopting training-of-trainers' models so that counties maintain a pool of trained mentors to cascade skills locally. Further, institutionalize capacity building by integrating adolescent-friendly SRH services training into county human resource for health systems to ensure continuity despite routine transfers; digitizing training using learning platforms such as Moodle to expand reach, especially given the current global health financing cuts which have made it harder to provide in-person physical training; and establishing rapid onboarding protocols and digital training modules for new providers to minimize service gaps and reduce retraining costs.

Leverage unintended positive outcomes by expanding awareness and service access strategies that have driven increased uptake among women above 19, without diluting the adolescent focus, and using this expanded demand as an entry point for family-based and community-level interventions to normalize SRH discussions.

Sustainability and exit strategy: Secure predictable financing through domestic systems by utilizing the convening power of the UN agencies to strengthen advocacy at National Treasury and county levels for ASRH/HIV budget lines; lobbying counties to provide budgetary resources to support ASRH/HIV services as embedded in the CAWPs and CIDPs; lobbying for expansion of SHA benefits package to include reimbursement for ASRH/HIV services; and encouraging eligible adolescents (above 18 years) and young people to acquire national identification cards and register in SHA in anticipation of coverage of SRH/HIV and other services.

Deepen community and adolescent/youth ownership by expanding peer-led and adolescent champion models to sustain demand generation and counter social stigma; working with CBOs to on-board mobilizers (including young people) as community health promoters within the government system, and incorporating young peer providers into the primary care networks models.

Prepare for subsequent phases (based on availability of funding) with adaptive design by incorporating lessons learned such as inclusion of more beneficiaries, expansion of service package, technology challenges, fraud risks, and staff turnover, into restructured subsequent phases, and ensuring that subsequent phases emphasize sustainability mechanisms from inception, hence reducing reliance on external financing over time. For the exit strategy, define a clear roadmap for transition of financial and operational responsibility from the Joint Program partners to counties and the SHA; and pilot phased handovers in selected counties to test mechanisms for government ownership before scaling down nationally.

Looking forward, position the ASRH-DIB within the recently announced Gates Foundation's $2.5B 10-Year Investment in Women's Health, focusing on innovations in contraceptive technologies, STI prevention and treatment, maternal health, and menstrual health. With the Foundation's new regional office in Nairobi, there is a strategic opportunity to frame and pitch the ASRH-DIB as a living laboratory for implementation research. The Joint Program can demonstrate how Gates Foundation-funded innovations in women's health research and development (R&D) such as next-generation contraceptives or HIV prevention technologies, can be tested, adapted, and scaled in real-world adolescent SRH settings. This would in turn ensure that R&D investments translate into measurable health impact, while simultaneously generating policy-relevant evidence that the Joint UN Team can channel into global guidelines, accelerating uptake across sub-Saharan Africa and beyond.

Literature Review

Kenya is a youthful nation, with 75% of its population below the age of 35 years. Notably, 46% (approximately 21.9 million people) are below the age of 18, while adolescents aged between 10 and 19 years constitute 11.6 million of the population [1]. This demographic structure underscores the urgent need for targeted investments in adolescent health, particularly sexual and reproductive health (SRH) and HIV services.

Adolescents in Kenya face disproportionate SRH risks. The country records approximately 250,000 adolescent pregnancies each year, contributing to a 15% national teenage pregnancy rate [2]. Among married adolescent girls, 22% have an unmet need for contraception – the highest among any demographic group [3]. Despite these high needs, only 23% of public health facilities in Kenya are considered youth-friendly [4], limiting access to critical SRH services. On the HIV front, 38% of all new adult infections occur among young people aged 15–24, with adolescent girls aged 15–19 being four times more likely to contract HIV compared to their male peers [5].

These challenges are compounded by macro-level constraints. Kenya's transition to a lower-middle income country has triggered a reduction in official development assistance (ODA), while private capital for social good remains underutilized [6]. This financing gap has necessitated innovative approaches to mobilize resources for adolescent health. The Adolescent Sexual and Reproductive Health Development Impact Bond (ASRH-DIB) responds directly to these challenges. Implemented by a consortium including UNFPA, WHO, UNAIDS, the SDG Partnership Platform (SDGPP), Tiko and the Government of Kenya, the two-year pay-for-success initiative aims to reach over 500,000 adolescent girls aged 15–19 years across ten high-burden counties: Nairobi, Mombasa, Kisumu, Homa Bay, Bungoma, Migori, Kisii, Nyamira, Kakamega, and Busia. The Program builds on a successful $6.6 million DIB model previously implemented by CIFF, FCDO, and Tiko between 2020 and 2022 [7].

The ASRH DIB targets three interrelated problems: (1) identifying adolescents with undiagnosed HIV and linking them to care and treatment, (2) ensuring continuity of HIV treatment and achieving viral suppression among adolescents on antiretroviral therapy, and (3) addressing the unmet need for contraception and unintended pregnancies among adolescent girls. To do this, the Program employs a digital platform with real-time data capabilities, enabling girls to select their preferred mode and location for accessing services. For those without mobile phones, access is facilitated via a smart card system. Services are delivered through a broad network of public and private facilities, including pharmacies, ensuring both quality and variety in service provision. As of now, 1.5 million adolescent girls are enrolled on the platform.

The short-term outcomes of the Program include: (i) increased agency among adolescent girls to exercise their SRH rights, (ii) increased utilization of quality SRH and HIV services within the public sector, and (iii) increased availability of public and private resources for adolescent SRH and HIV services in Kenya. Long-term outcomes are aligned with key SDG targets and include reductions in new HIV infections, AIDS-related deaths, and adolescent pregnancies.

The ASRH DIB thus represents a timely and innovative response to the intersecting health and financing challenges facing Kenya's adolescents. It also offers a scalable model for addressing similar issues in other low- and middle-income countries.

Joint Program Background Information

The design of the UN Joint Program (JP) started in 2020 and was approved for funding by the Joint SDG Fund in January 2022. The JP was awarded $7 million in 2022 from the Joint SDG Fund as catalytic funding towards improving adolescent SRH and HIV outcomes in the country, with the public and the private sectors being the main areas of focus in service delivery. In 2023, the JP received an additional $5 million from CIFF, signaling the start of implementation of the program.

The JP adopts a Development Impact Bond (DIB) as its financial instrument where potential social investors pre-finance the JP for a return. The JP is expected to mobilize additional resources from both private and public sources to leverage the support received from the Joint SDG Fund and CIFF so as to reach more adolescent girls with SRH and HIV services in Phase 2. The JP implementation commenced in July 2023.

Purpose of the Mid-Term Review

The purpose of the mid-term review (MTR) was to:

- Assess the progress towards the achievement of the ASRH DIB objectives and key results, both developmental and financial, as specified in the project document.
- Assess early signs of programmatic success or failure.
- Identify the necessary changes to be made, if required, in order to ensure that the JP is on-track to achieve its intended results.
- Review the strategy of the JP and risks to sustainability.

Scope of the Mid-Term Review

The consultant performed the review based on the following domains as specified in the terms of reference:

i. Design
ii. Progress/Results to date
iii. Management Efficiency
iv. Risk Management
v. Sustainability and Exit Strategy

Design

In this domain, the consultant reviewed:

- How the program propels the key SDG targets especially considering the JP's intended focus on unlocking additional resources for the SDGs.
- Whether the JP strategy is in line with the national development priorities and UN Sustainable Development Cooperation Framework (UNSDCF) of the country.
- The country ownership of the program – both from public and private sector partners.
- The relevance and effectiveness of the proposed financial instruments and other programmatic interventions.
- The extent to which relevant gender, youth and other Leaving No One Behind (LNOB) issues were raised in the design of ASRH DIB program, including reviewing that the results framework incorporates key considerations and disaggregated data on gender and other LNOB dimensions both in their development and financial results.
- The logical framework indicators and targets, assessing how SMART (Specific, Measurable, Attainable, Relevant, Time-bound) the indicators are, and whether the midterm and end-of-project targets are realistically achievable.
- The implementation timeframe and whether it is sufficient to complete planned activities and achieve envisaged results.

Progress/Results

Here, the consultant:

- Reviewed the key results achieved against the results framework especially in relation to the key outcome indicators and their end-of-project targets.
- Color coded progress in a 'traffic light system' based on the level of progress achieved per outcome area, assigning a rating on the progress for the program objective and each outcome.
- Reviewed whether the results/progress to date has the potential to achieve systemic change and/or demonstrative impact in the future, beyond the JP to catalyze change, innovation, and evolution in the health financial sector – either public, private, or developmental – in the country to devise new means or solutions to unlock additional financing for the healthcare sector.
- Reviewed whether the financial solutions/instruments developed have led to (or have the potential to lead to) developmental impact for the local communities and population as well as the environment in terms of accelerating SDG achievements.
- Assessed the extent to which the solutions developed to date could be scaled to other counties and /or economic sectors.
- Identified areas that the JP could benefit from the learning agenda based on innovations and best practices uncovered from data collection processes at all levels.
- Reviewed the scope and scale of additional financing leveraged by the program including whether co-financing targets are being realized using the Financial Leverage Monitoring Table based on inputs from the JP design team.
- Provided reflections on ways in which the program has been able to unlock additional financing or why additional financing has been limited.
- Assessed overall effectiveness of the JP in achieving its intended objectives.

Management Efficiency

In this domain, the consultant reviewed management efficiency under three sub-domains, namely:

Management arrangements:

- Overall efficiency of ASRH DIB management as outlined in the project document. Specifically:
    - Were changes made and if so, were they efficient?
    - Were responsibilities and reporting lines clear?
    - Was decision-making transparent and undertaken in a timely manner?
    - Was there an ASRH-DIB governance body formally established with clear roles?
- Quality of execution of the UN Joint Team including WHO, UNFPA, UNAIDS & SDGPP and the implementing partner (Tiko).
- Role and quality of coordination and oversight provided by the UNRCO's office.

Reporting and communications:

- How well the JP team and partners undertake and fulfil the ASRH DIB reporting requirements.
- How results and lessons derived from the Program have been documented, shared with key partners, and internalized by partners.

External communications:

- Whether there were proper means of communication established or being established to inform the program's progress and intended impact to the stakeholders and the public at large.
- Whether the communications efforts have been efficient and sufficient in order to inform the adolescent girls (program beneficiaries) on the new health and reproductive services available.
- Whether the ASRH DIB communication strategy was developed and if it's being followed.
- Whether the communications products reflect the "joint" nature of the JP.
- Identified gaps in communication and visibility of the JP that the joint team could galvanize and leverage on their existing structures and mechanism to address in order to improve quality and adolescent friendly services.

Risk Management

In this domain, the consultant:

- Validated whether the risks identified in the project document and annual reports were the most important and whether the risk ratings applied are appropriate and up to date.
- Identified socio-economic, political, or other risks that may jeopardize sustainability of the ASRH DIB outcomes.
- Identified unintended positive or negative effects observed because of the ASRH DIB interventions.

Sustainability and Exit Strategy

In this domain, the consultant:

- Reviewed the likelihood of the financial sustainability of the financial instruments once the ASRH DIB comes to an end.
- Reviewed whether the financial instruments have sufficient country buy-in from the relevant public and private partners, from the demand and supply sides, to ensure sustainability following the completion of the program.
- Examined whether the JP has a realistic and feasible exit strategy and approach to phase out assistance, including the need to transfer responsibility to local stakeholders.
- Assessed the possibility of the actions and results from project interventions being sustained, ideally through ownership by the local partners and stakeholders.
- Identified whether the JP had developed and leveraged the necessary and appropriate partnerships – both public/private and developmental – to achieve its intended results and ensure sustainability.
- Identified the key factors that will require attention to improve prospects of sustainability, scalability, or replication of project outcomes/outputs/results in future.
- Assessed the feasibility of proceeding with a phase 2 based on successes, challenges and lessons learned from phase 1.

Approach and Methods of the Mid-Term Review

Overall Approach

The JP review process applied a collaborative and participatory approach ensuring close engagement with the UN Joint team, government counterparts including Ministry of Health, Council of Governors and county government health officials from the participating counties, private and public sector partners and direct beneficiaries.

Study Design

The MTR adopted a mixed-methods approach, combining both quantitative and qualitative data to ensure a comprehensive understanding of the ASRH DIB program's performance.

Sampling Criteria

The review adopted a purposive sampling approach, which is well-suited for qualitative evaluations that seek depth, relevance, and contextual insight over statistical generalizability. This approach allowed the selection of information-rich participants who were directly engaged in the design, governance, implementation and utilization of the JP across the ten target counties and national-level institutions. The sampling enabled deliberate inclusion of respondents across geographical clusters, institutional roles, and levels of engagement to ensure a comprehensive understanding of what was working, where, and why.

Data Collection Tools

Data collection tools were prepared to elicit information from participants based on the scope of the MTR of the ASRH-DIB which had five criteria, namely: Design, Progress/Results to date, Management Efficiency, Risk Management, and Sustainability/Exit Strategy. The tools included: a desk review checklist, key informant interview guides, and focus group discussion guides. The tools are included in the report as ***Annex 1.***

Data Collection Procedures

A combination of robust data collection methods was used as outlined below:

Document/Desk Review: Relevant sources of information including documents prepared during the ASRH DIB project document, biannual evaluation reports, national strategic and legal documents were reviewed. A complete compilation of the documents reviewed in support of each of the MTR criteria is provided as Annex 1.1.

Key Informant Interviews (KIIs): KIIs were held with stakeholders with programmatic responsibilities, including representatives from: Donors and financiers of the program including Bridges Outcome Partnerships, Joint SDG Fund and CIFF); Participating UN agencies (UNFPA, WHO, UNAIDS, SDG PP, UNRCO); Implementing partner (Tiko), National government agencies at the Ministry of Health (National AIDS and STI Control Program (NASCOP), National Syndemic Diseases Control Council (NSDCC), Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) Division); County governments (County Reproductive Health Coordinators, County Adolescent & Youth Sexual Reproductive Health Focal Persons, County AIDS & STIs Coordinators (CASCOs); Healthcare providers from pharmacies, private and public healthcare facilities; and Mobilizers from community-based organizations (CBOs). A majority of the interviews with international and national participants were held virtually on the Google Meet platform, whereas most of the interviews at the county levels were held in-person.

Focus Group Discussions (FGDs): These were held with adolescent girls aged 15 – 19 years to gather lived experiences and perceptions on program relevance, access, and impact. All FGDs were held in-person.

Data Management and Quality Assurance

To ensure rigor in data derived from desk reviews, a structured approach was employed. Documents were categorized by source (e.g. project documents, UN documents, national level documents, evaluation documents) and organized using a version-controlled repository. A standardized checklist was used to extract relevant information systematically, with all insights traceable to their original sources. Ethical protocols were observed through restricted access and secure handling of sensitive materials.

For qualitative data collected during the MTR, a standardized process was applied across both virtual and in-person KIIs/FGDs. Online KIIs conducted via Google Meet were audio-recorded using an Artificial Intelligence (AI) platform's integrated transcription features. In-person KIIs and FGDs were similarly recorded and transcribed using the same AI platform. All transcripts were securely stored in a centralized, access-controlled folder. Transcript checks were conducted against the original audio to correct transcription errors and ensure accuracy. Data were anonymized prior to analysis, and a thematic coding framework was applied consistently across transcripts to support reliability and transparency in interpretation.

Data Analysis

Data was analyzed using a domain-based framework aligned with the MTR matrix.

Quantitative data from program monitoring systems such as biannual evaluation reports, were analyzed using descriptive statistics such as frequencies, percentages, and trends over time. Data were disaggregated by various parameters e.g. for SRH/HIV accessed by adolescent girls, these were disaggregated by county, type and where accessed (pharmacies, private or public health facilities).

Qualitative data from KIIs and FGDs were analyzed thematically using a deductive-inductive coding framework aligned with the five review domains (Design, Progress, Management Efficiency, Risk, and Sustainability/Exit Strategy). Transcripts were coded using the aforementioned AI platform. Emerging themes were compared across respondent types (e.g., county officials, adolescent girls) to identify recurring patterns, divergences, and context-specific insights.

The MTR employed data triangulation to enhance the validity, reliability, and depth of its findings by systematically integrating evidence from multiple sources: KIIs, FGDs, desk review documents, and Program monitoring data. This approach ensured that the analysis reflected diverse perspectives and reduced bias.

Review Matrix

The matrix served as the foundational tool guiding the MTR. It outlined the key review questions, indicators, data sources, collection methods, sampling strategies, and analysis approaches, all aligned with the five core review domains: design, progress/results, management efficiency, risk management, and sustainability/exit strategy. The matrix provided a structured framework to ensure comprehensive data collection, facilitate triangulation across methods, and support a consistent, criteria-driven assessment of the ASRH DIB program's performance. The full review matrix is provided as **Annex 2** in the MTR report.

Challenges Experienced and Contingency Measures

Two key challenges affected the MTR fieldwork. First, delays in logistical support reduced the planned data collection period from 20 to 13 days. To mitigate this, the team worked intensively and adapted schedules to complete fieldwork in 9 out of 10 counties. In Mombasa, only virtual interviews with county government officials were conducted due to time constraints, ensuring key perspectives were still captured despite limited engagement. Second, scheduling interviews with high-level stakeholders proved difficult, as many had limited availability due to competing commitments. Despite multiple follow-ups via email, WhatsApp, and phone calls, the process remained slow and further strained the shortened timeframe. The team mitigated this by adjusting interview times, including early mornings and late evenings, to secure critical insights from these stakeholders.

Ethical Considerations

The review adhered to established ethical standards for research involving human participants and was guided by the United Nations Evaluation Group (UNEG) Ethical Guidelines. Verbal informed consent was obtained from all participants, with special provisions for adolescents under 18, including guardian assent (provided by mobilizers) or application of the emancipated/mature minors principle in line with Kenya's ASRH Policy (2015). Participation was voluntary, and confidentiality and anonymity were assured. Data collection tools and procedures were culturally appropriate, gender-sensitive, and youth-friendly. To safeguard adolescent girls in FGDs, facilitators were carefully selected, sessions held in discreet venues, and discussions structured to build trust before addressing sensitive topics. Facilitators were trained to manage distress and provide appropriate referrals when needed.

Findings

Participant Characteristics

The characteristics of participants who took part in the MTR are presented in **Tables 1 – 6** below:

Table 1: Summary of all participants (N=214)

All Participants		
Category	**Frequency**	**Percentage**
High-level partners	19	8.9
CG officials	25	11.7
HCPs	41	19.2
Mobilizers	31	14.5
Adolescent girls	98	45.8
Total	**214**	**100.0**

A total of 214 participants took part in the MTR, with 98 adolescent girls aged 15 – 19 years representing almost half of the participants (45.8%), and showing the emphasis that the MTR placed on obtaining the perspectives of the targeted beneficiaries of the JP.

Table 2: Characteristics of high-level partners

High Level Partners		
	Gender	
Partner	**Man**	**Woman**
SDG Fund	1	1
UNFPA	1	0
UNAIDS	1	2
WHO	1	1
UNRCO/SDG PP	0	1
Tiko	0	3
NSDCC	0	1
NASCOP	1	3
RMNCAH	2	0
Total	**7**	**12**
Percentage	**36.8**	**63.2**

Project donors and financiers, participating UN agencies, national government officials and the implementing partner Tiko were classified as high-level partners for the purpose of the MTR, and with 19 representatives interviewed, represented close to a tenth (8.9%) of all study participants. At 63.2%, the proportion of women interviewed was higher than that of men at 36.8%.

Table 3: Characteristics of county government officials (n=25)

County Government Officials					
County	**Gender**		**Designation**		
	Man	**Woman**	**CRHC**	**CASCO**	**CAYP-FP**
Bungoma	2	1	1	1	1
Busia	1	1	1	1	0
Homabay	3	0	1	1	1
Kakamega	1	2	1	1	1
Kisii	1	2	1	1	1
Kisumu	2	1	1	1	1
Migori	1	1	0	1	1
Mombasa	0	2	0	1	1
Nairobi	1	1	0	1	1
Nyamira	1	1	1	1	0
Total	**13**	**12**	**7**	**10**	**8**
Percentage	**52.0**	**48.0**	**28.0**	**40.0**	**32.0**

Key: CRHC: County Reproductive Health Coordinator, CASCO: County AIDS and STI Coordinator, CAYP-FP: County Adolescents and Young People Focal Person

A total of 25 county government officials from the respective departments of health were interviewed, with the proportion of men and women interviewed almost equal. In half of the counties, all three officials sampled for participation took part in the MTR, whereas in the other half two out of three officials participated. This was mainly due to competing commitments, as well as some of the officials being on annual leave at the time of fieldwork.

Table 4: Characteristics of county healthcare providers (n=41)

Healthcare Providers									
County	**Gender**		**Facility Type**			**Cadre**			
	Man	**Woman**	**Pharmacy**	**Private**	**Public**	**RCO**	**NO**	**HTSP**	**PT**
Bungoma	0	2	0	1	1	0	2	0	0
Busia	2	4	2	2	2	1	2	2	2
Homabay	1	3	1	1	2	1	1	1	1
Kakamega	2	3	1	1	3	2	1	1	1
Kisii	3	1	0	3	1	1	1	1	0
Kisumu	1	7	1	2	5	1	4	2	1
Migori	1	3	0	3	1	0	2	2	0
Mombasa	0	0	0	0	0	0	0	0	0
Nairobi	1	2	0	2	1	1	1	1	0
Nyamira	1	4	1	3	1	1	3	0	1
Total	**12**	**29**	**6**	**18**	**17**	**8**	**17**	**10**	**6**
Percentage	**29.3**	**70.7**	**14.6**	**43.9**	**41.5**	**19.5**	**41.5**	**24.4**	**14.6**

Key: HTSP: HIV testing services provider, NO: Nursing officer, PT: Pharmaceutical technologist, RCO: Registered clinical officer

A total of 41 healthcare providers took part in the MTR, with more than two thirds (70.7%) being women. Almost equal proportions of the providers worked in private and public health facilities, with the rest being pharmacy-based. A majority of providers were NOs, followed by RCOs, HTSPs and PTs in that order.

Table 5: Characteristics of mobilizers (n=31)

Mobilizers		
County	**Gender**	
	Man	**Woman**
Bungoma	1	1
Busia	0	5
Homabay	1	4
Kakamega	1	2
Kisii	0	5
Kisumu	0	2
Migori	0	4
Mombasa	0	0
Nairobi	0	3
Nyamira	1	1
Total	**4**	**27**
Percentage	**12.9**	**87.1**

A total of 31 mobilizers took part in the MTR. Apart from mobilizing the adolescent girls, they also took part in group interviews to offer their perspectives on the JP. Most of the mobilizers were women at 87.1%.

Table 6: Characteristics of adolescent girls aged 15 – 19 years (n=98)

Adolescent Girls (15 - 19 Years)							
County	**Frequency**	**Percentage**	**Age (Years)**				
			15	**16**	**17**	**18**	**19**
Bungoma	7	7.1	1	1	2	2	1
Busia	18	18.4	1	2	3	6	6
Homabay	8	8.2	2	2	1	1	2
Kakamega	11	11.2	1	3	2	3	2
Kisii	12	12.2	2	2	1	4	3
Kisumu	12	12.2	2	1	2	4	3
Migori	8	8.2	1	1	2	1	3
Mombasa	0	0.0	0	0	0	0	0
Nairobi	12	12.2	2	2	2	3	3
Nyamira	10	10.2	2	2	2	2	2
Total	**98**	**100.0**	**14**	**16**	**17**	**26**	**25**
Percentage	**100.0**		**14.3**	**16.3**	**17.3**	**26.5**	**25.5**

A total of 98 adolescent girls took part in the MTR, representing the highest proportion of participants. Busia county had the highest number of adolescent girls (18) who participated, with most of the counties having 10 or more adolescent girls participating. In terms of age, adolescent girls aged 16, 17 and 18 years were in almost equal proportions, followed by those aged 19 years and 16 years in that order.

Design

The bullet points under the design criterion as specified in the scope of the MTR were converted to review questions. The following section lists the respective review questions, followed by a detailed description of responses to the questions, based on the findings of the MTR.

- **How does the program contribute to key SDG targets and mobilization of additional resources?**
  By delivering adolescent-responsive contraception and HIV services (testing, PrEP, ART) to girls aged 15–19 years, the ASRH-DIB made measurable contributions to multiple SDG targets:
  - SDG 3.3: Helped reduce HIV incidence by increasing access to testing, timely ART initiation for those testing positive, and prevention options (PrEP) for at-risk girls.
  - SDG 3.7: Expanded access to modern contraceptive methods and counselling, lowering unmet need and adolescent birth rates through adolescent-friendly and confidential services.
  - SDG 3.8: Supported universal health coverage (UHC) by providing SRH and HIV services at no or minimal cost, reducing financial barriers for adolescents.
  - SDG 5.1: Reduced gender-based barriers and discrimination in accessing SRH services by training providers in respectful, equitable care.
  - SDG 5.6: Strengthened adolescent girls' autonomy in making SRH decisions by ensuring confidential services, informed choice, and alignment with Kenya's ASRH Policy (2015) on emancipated/mature minors.
  - SDG 17.3: Mobilized additional financial resources through a blended financing model where private investors provided upfront capital repaid on verified results.
  - SDG 17.16: Fostered multi-sector partnerships between government, donors, investors, and implementers, enabling integrated service delivery.
  - SDG 17.18: Strengthened data quality and use by improving routine reporting systems, dashboards, and verification processes, thus increasing credibility with funders and attracting further investment.

  Collectively, these contributions reduced SRH-related risks, improved health outcomes, empowered adolescent girls, and enhanced financial and data systems for sustainable impact.

- **Is the JP strategy aligned with national development priorities and Kenya's UN Sustainable Development Cooperation Framework (UNSDCF)?**
  Yes.
  - The program is well aligned with Kenya's national priorities and the UN Sustainable Development Cooperation Framework (UNSDCF) 2022–2026. Kenya has an explicit, government-led "End the Triple Threat" agenda to curb new HIV infections, untimed pregnancies, and gender-based violence (GBV) among adolescents and young people by 2030 (with interim national commitments and a 2023–2030 plan). These commitments are further reflected in the county integrated development plans (CIDPs), and county annual work plans (CAWPs). By providing adolescent-responsive contraception and HIV services, the program advances that agenda directly.
  - The program also maps to the UNSDCF Strategic Priority 1 (People & Peace), Outcome 1.2, which commits the UN and government to enhance inclusive, equitable health (including RMNCAH) and HIV services for women, girls, and youth, with explicit SDG 3 indicators (e.g., 3.3, 3.7) listed in the results framework. In addition, the program's partnership model, routine data strengthening, and results-based financing approach mirrors the UNSDCF's partnership and data-for-development enablers, supporting SDG 17 on financing, coordination, and data quality.

- **To what extent is there public and/or private sector ownership of the program?**
  The program demonstrates strong shared ownership, with active participation from both national and county government agencies and private service providers.
  - At the national level, key agencies – including RMNCAH, NSDCC and NASCOP, were engaged from the onset in the program's co-creation and design. They continue to play a role in oversight, policy alignment, and technical guidance**,** ensuring that the program's strategies are consistent with Kenya's health sector priorities, including the "End the Triple Threat" agenda.
  - At the county level, governments in participating counties are actively involved in implementation, support supervision, joint monitoring and data quality audits**.** They also participate in quarterly review meetings and other governance forums, contributing to data review, problem-solving, and the adaptation of service delivery strategies to local contexts.
  - The private sector is a significant implementation partner, with private health facilities delivering nearly 75% of contraceptive services and more than half of HIV services within the ASRH-DIB framework. This broadens service reach, increases choice for adolescents, and leverages private sector capacity to complement public sector delivery.

Overall, this integrated governance and delivery model that combines national leadership, county-level ownership, and private sector engagement, has fostered a high degree of program ownership, sustainability potential, and alignment with Kenya's mixed health system reality.

- **How relevant and effective are the financial instruments and programmatic interventions?**
  The combination of a high-performing financing mechanism and well-targeted interventions positions the program as both impactful in the short term and sustainable in the long term. Specifically:
  - The ASRH-DIB's financial mechanism has proven highly relevant to Kenya's ASRH and HIV priorities. By linking investor repayment to independently verified outcomes, the instrument incentivizes performance, encourages adaptive management, and promotes accountability across all implementing partners.
  - The results-based financing model also aligns with national and global priorities for efficiency and measurable impact, making it a strong fit for scaling evidence-based interventions in resource-constrained settings.
  - Programmatically, the interventions, comprising adolescent-friendly contraceptive and HIV services, and community outreach, are directly responsive to the needs of adolescent girls aged 15–19 years, and address the "Triple Threat".
  - Service delivery has been strengthened through both public and private facilities, leveraging Kenya's mixed health system to increase access and choice.
  - Effectiveness is evidenced by the fact that most mid-term targets have already been surpassed**,** demonstrating strong uptake of services, efficient implementation, and responsiveness to adolescent needs. The DIB structure has facilitated real-time performance monitoring, enabling timely adjustments to strategies and resource allocation, which in turn has accelerated progress towards targets.

- **Were gender, youth, and other Leaving No One Behind (LNOB) considerations integrated into program design and the results framework?**
  The program's design and results framework explicitly target adolescent girls aged 15–19, with strong integration of gender, youth and age considerations to address the high burden of unintended pregnancies and new HIV infections among this group. This targeted approach aligns with the "Triple Threat" agenda and reflects the disproportionate vulnerabilities faced by adolescent girls in Kenya. However, the LNOB review identified four priority areas for strengthening equity in the ASRH-DIB: ensuring identity validation systems are accessible to adolescents with disabilities, inclusion of girls aged 10-14 years and young people aged 20-24 years, including boys and young men in the program, and broadening the service package, as detailed below:

a) Identity validation through voice recognition:

The requirement for girls to validate their identity using voice recognition creates an unintended barrier for adolescents with hearing or speech disabilities. This excludes them from accessing services independently and contravenes the LNOB principle, as it indirectly discriminates based on disability status. Stakeholders noted that such requirements may discourage affected adolescents from seeking SRH/HIV services altogether. However, Tiko clarified that a manual exemption process exists at facilities to ensure that such girls can still access services without recording a voice. While the manual exemption process does provide an alternative, this creates a risk of inconsistency, where some girls might be excluded if the exemption process is not uniformly applied or if providers are not adequately trained to recognize and accommodate disability needs. From a LNOB perspective, reliance on ad hoc exemptions is less robust than embedding inclusive, standardized alternatives directly into the system design.

b) Inclusion of adolescent girls aged 10 – 14 years and young people aged 20 -24 years:

While the ASRH-DIB design targets adolescent girls aged 15–19 years, stakeholder consultations, especially with county officials, healthcare providers and adolescent girls, revealed important gaps in age inclusivity:

- Exclusion of younger adolescents (10–14 years): Approximately 10% of adolescent girls in Kenya initiate sexual activity before age 15, placing them at measurable risk of unintended pregnancy and HIV. The absence of tailored services for this group leaves early initiators without timely access to SRH, HIV prevention, and protection services.
- Transition gap for older adolescents: Girls nearing the upper age limit expressed concern about losing eligibility upon turning 20. Many noted that vulnerabilities, such as unintended pregnancy risk, HIV exposure, and GBV, extend well into their early twenties. Sustaining eligibility until age 24 would align with Kenya's classification of "youth" and international definitions of "young people," ensuring continued access during a critical life stage marked by navigating tertiary education, entry into the workforce, and relationship formation.

c) Inclusion of boys and young men in program design and interventions:

- A recurring concern raised by multiple stakeholders was the exclusion of boys and young men from the program's design and interventions. While focusing on girls is essential, stakeholders cautioned that overlooking boys and young men can be counterproductive. Since both parties influence SRH/HIV outcomes ("it takes two to tango" and "the girls do not impregnate themselves"), the absence of male engagement risks perpetuating gender norms, misinformation, and behaviors that contribute to the very challenges the program seeks to address. Without targeted interventions for boys and young men, such as SRH education, HIV prevention services, and positive masculinity programs, progress in reducing unintended pregnancies, HIV infections and GBV may be slower and less sustainable.

Broadening the service package to include gender-based violence, sexually transmissible infections, cervical cancer screening and HPV vaccine uptake, and mental health services:

Stakeholders highlighted the need to broaden the package of services offered to adolescent girls, since many of them face intersecting challenges affecting their overall wellbeing. Specifically, stakeholders noted that comprehensive adolescent services programming should include:

- **Gender-based violence (GBV):** Prevention, screening, response, and referral mechanisms for survivors. This would directly strengthen Kenya's response to the "Triple Threat" since GBV is both a driver and outcome of new HIV infections and untimed pregnancies among adolescent girls.
- **Sexually transmissible infections (STIs):** Routine screening, diagnosis, treatment, contact tracing and education to reduce transmission and reinfection. These were noted as common among the adolescent girls, necessitating interventions since STIs biologically potentiate the transmission and acquisition of HIV.
- **Cervical cancer prevention:** Access to screening services and strengthening promotion and delivery of the human papillomavirus (HPV) vaccine, as a critical preventive intervention. Uptake of the vaccine remains low despite the government's efforts to increase availability and accessibility of the vaccine.
- **Provision of sanitary pads:** Sanitary pads are complementary goods to SRH services, and insufficient access exposes girls to risks such as transactional sex ("sex for pads"), which undermines SRH outcomes by increasing vulnerability to unintended pregnancies, HIV, and STIs. Linking incentives to pads would therefore strengthen program effectiveness, not just satisfy adolescent preferences.
- **Mental health services:** Screening, counselling, psychosocial support, and referral linkages integrated within ASRH/HIV services. Participants highlighted that issues such as anxiety, depression, stress, and trauma (including experiences related to GBV or HIV diagnosis) can significantly influence the ability to make informed SRH decisions, adhere to HIV prevention or treatment, and engage consistently with care. It was noted that mental health services have been provided on the Tiko platform in the county of Mombasa with demonstrated benefits as narrated in Calista's Journey with the ASRH-DIB.

  Expanding the service package in this way was viewed as critical to addressing the holistic health needs of adolescents and strengthening the long-term sustainability and impact of the program.

- **Are the logical framework indicators SMART (Specific, Measurable, Attainable, Relevant, Time-bound), and mid-term and end-of-project targets realistically achievable?**
  The logical framework indicators for the ASRH-DIB are generally **SMART**:
  - **Specific:** Indicators are well-defined, focusing on adolescent girls aged 15–19 and tracking key outputs/outcomes such as contraceptive uptake, HIV testing, PrEP and ART initiation/refills.
  - **Measurable:** All indicators are quantifiable, with data routinely captured through service delivery registers, Kenya Health Information System (KHIS), and independent verification mechanisms.
  - **Attainable:** Given program performance to date, most targets are achievable within the project period, aided by adaptive management and results-based incentives under the DIB model.
  - **Relevant:** Indicators align with the project's theory of change, national ASRH/HIV priorities, and the "End the Triple Threat" agenda.
  - **Time-bound:** Mid-term and end-of-project targets are clearly time-framed and aligned to the DIB's contractual milestones.

Realistic achievement of targets:

- **Mid-term:** Most mid-term targets have already been met or surpassed, indicating both the feasibility and ambition of the targets. This reflects effective service delivery, strong demand-generation, and leveraging of both public and private sector platforms.
- **End-of-project:** Based on current trends, end-of-project targets are not only realistically achievable but can also be surpassed, provided that high performance is maintained and that the program continues to adapt to contextual challenges discussed in subsequent sections of the report.

Overall, indicators meet **SMART** criteria, and target-setting process appears realistic. Continued adaptive management, attention to service quality, and demand-generation will be key to sustaining momentum and achieving end-line goals.

- **Is the implementation timeframe sufficient to complete planned activities and achieve envisaged results?**

  The current implementation timeframe appears generally sufficient to complete the planned activities and achieve envisaged results, given the strong progress recorded to date. Most mid-term targets have been met or exceeded, indicating that the pace of implementation is on track. The DIB's results-based financing structure has incentivized efficiency, enabling rapid scale-up of service delivery through both public and private sector facilities.

- **Tiko miles as a cross-cutting issue**

  Tiko miles, the incentive mechanism embedded within the ASRH-DIB, emerged as a cross-cutting issue shaping the experiences of adolescent girls, mobilizers, and healthcare providers alike. While designed to encourage service uptake, feedback from the field revealed that nearly all stakeholders saw the current incentive levels as inadequate, limiting their potential impact.

  Adolescent girls:

  - Adolescent girls currently receive 40 Tiko miles per service, equivalent to 40 Kenyan shillings. In focus group discussions, nearly all girls proposed raising this to 80–100 miles, the cost of a month's supply of the most affordable sanitary pads. The girls emphasized that pads are essential for school attendance and dignity, and directly linked to SRH needs.
  - The request is fair and grounded in lived realities. Sanitary pads are complementary goods to SRH services, and insufficient access exposes girls to risks such as transactional sex ("sex for pads"), which undermines SRH outcomes by increasing vulnerability to unintended pregnancies, HIV, and STIs. Linking incentives to pads would therefore strengthen program effectiveness, not just satisfy adolescent preferences.
  - Increasing the value of the nudges to **80-100 miles per service** would enable girls to redeem pads consistently, align incentives with real adolescent needs, enhance program attractiveness and sustained service uptake, and contribute to reducing gendered vulnerabilities such as transactional sex.
  - Tiko has acknowledged this concern but highlighted that directly increasing Tiko Miles to 80–100 may raise issues of cost-efficiency and sustainability. Instead, the client suggests exploring partnerships with corporate social responsibility (CSR) initiatives or private sector actors who could support provision of sanitary pads, either in-kind or through subsidized supply chains.

  Mobilizers

  - Mobilizers currently receive 125 miles for successfully enrolling a girl (meaning the girl has accessed services) via mobile phone and 75 miles for card-based successful enrollment. Since most vulnerable girls lack mobile phones, card enrollment is dominant, yet earns fewer miles. During the group interviews, mobilizers voiced dissatisfaction and proposed harmonizing and increasing the incentive.
  - The perception of inequity is valid. Both methods require similar effort, and the lower reward for card-based enrollment discourages mobilizers working with the most vulnerable adolescents. While the higher rate for mobile enrollment was meant to encourage digital adoption, limited mobile phone access among adolescents undermines fairness.
  - Harmonizing the incentive structure to remove disparities is logical. A fair rate could be **125 miles per successful enrollment** (meaning a girl has accessed services), regardless of method, balancing program equity with digital adoption goals. Incremental adjustments, coupled with other incentives such as recognition certificates for exemplary performance, and expanded adolescent digital access initiatives, would maintain alignment with Tiko's technology-driven model.

Public healthcare providers:

- Public healthcare providers reported that the current incentive of 20 Tiko miles per service is inadequate relative to the effort required. Providers frequently face challenges such as unreliable voice validation, lack of Wi-Fi in facilities, and the need to use personal airtime to log services. These barriers add hidden costs and effort, while accurate reporting remains central to program success.
- Providers proposed increasing incentives to 50–100 miles per service, arguing that this adjustment would better reflect the effort invested, boost morale, and sustain commitment to service provision.
- The providers' request is valid since the current incentive structure risks demotivation and data quality gaps. Revising the incentive to a fairer level, ideally within the range of **50-75 miles per service**, would balance provider effort with program sustainability.

Private healthcare providers:

- Private facilities are reimbursed for the services they deliver, but individual healthcare providers in private facilities do not receive Tiko miles.
- During fieldwork, the strongest calls for incentives came from providers working in larger facilities, with employed staff feeling left out compared to their public-sector counterparts.
- The concerns raised are valid. The current system disproportionately disadvantages providers in larger private facilities who are not proprietors, yet contribute significantly to ASRH/HIV service provision. Without direct incentives, their motivation and engagement may be undermined, even as facility reimbursements are received at ownership level.
- Introducing direct Tiko miles for private facility providers would maintain equity and sustain provider motivation. A range of **50-75 miles per service** appears fair since it matches what is proposed for public providers, ensures frontline staff in private facilities are equitably recognized for their efforts, and strengthens provider morale, ensuring quality service delivery and accountability across all types of facilities.

Overall, the MTR finds that while the Tiko miles system is an innovative and valued mechanism, adjustments are necessary to ensure fairness, strengthen motivation, and maintain program sustainability.

Progress/Results

- **Summary of progress/ results**
  The summary of the program's progress/results up to and including December 2024, is shown in **Figures 1- 11.** The summary shows what the key program targets were for July – December 2023, and January – December 2024, compared to the progress/results achieved during the same periods. In the graphs, targets are represented by blue bars, whereas results achieved are shown in green bars.

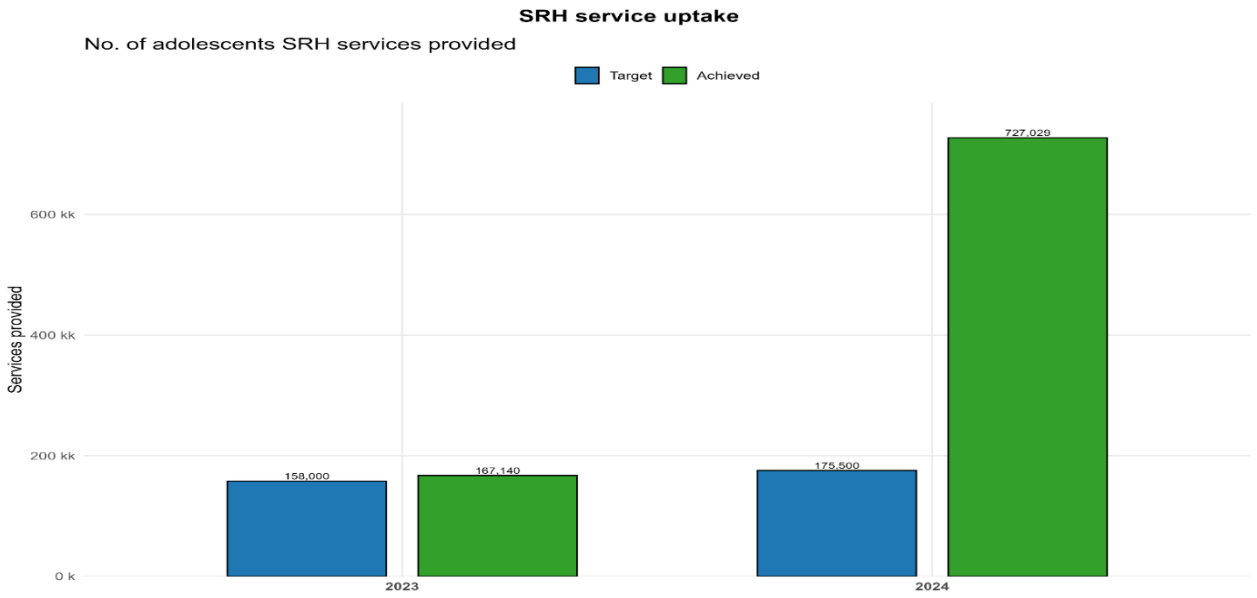

Figure 1: Number of all SRH services provided – 2023 & 2024 targets vs. results achieved

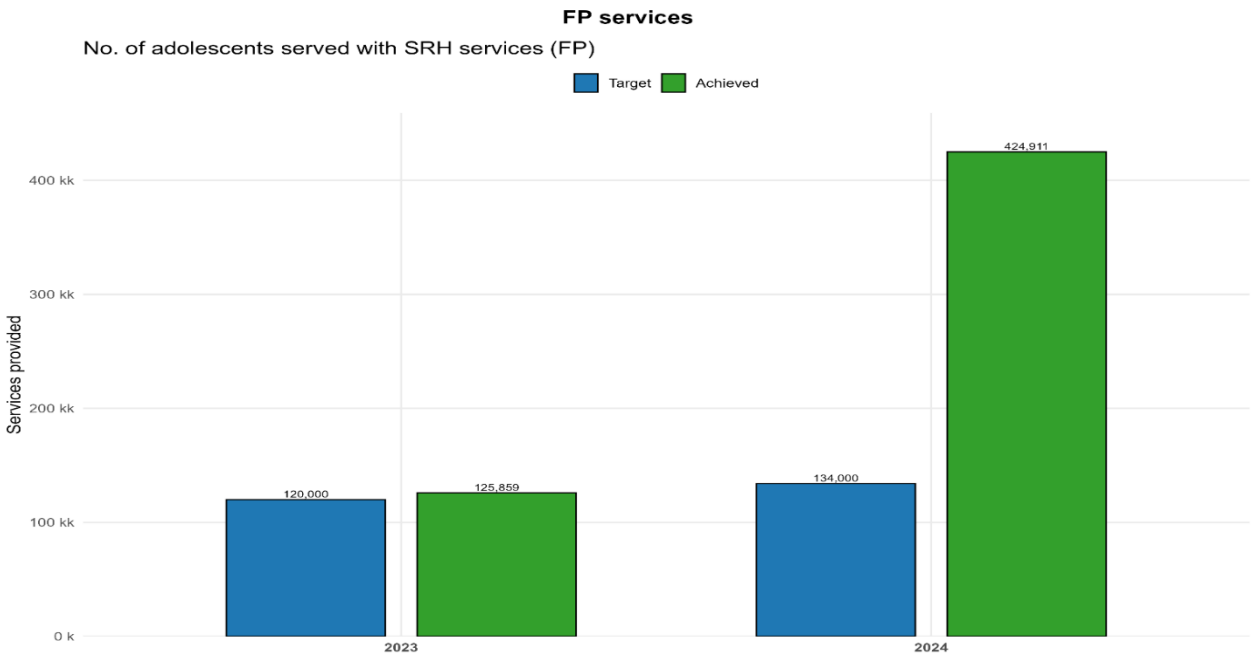

Figure 2: Number of adolescents served with SRH services – 2023 & 2024 targets vs. results achieved

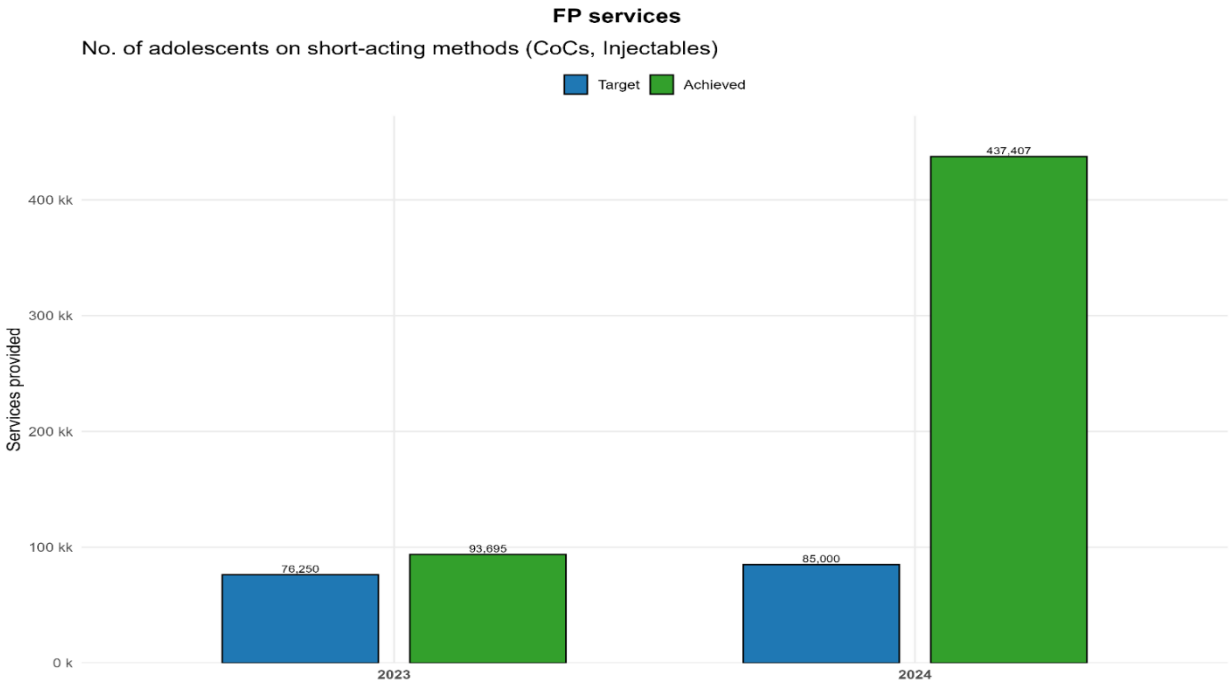

Figure 3: Number of adolescents on short-acting methods – 2023 & 2024 targets vs. results achieved

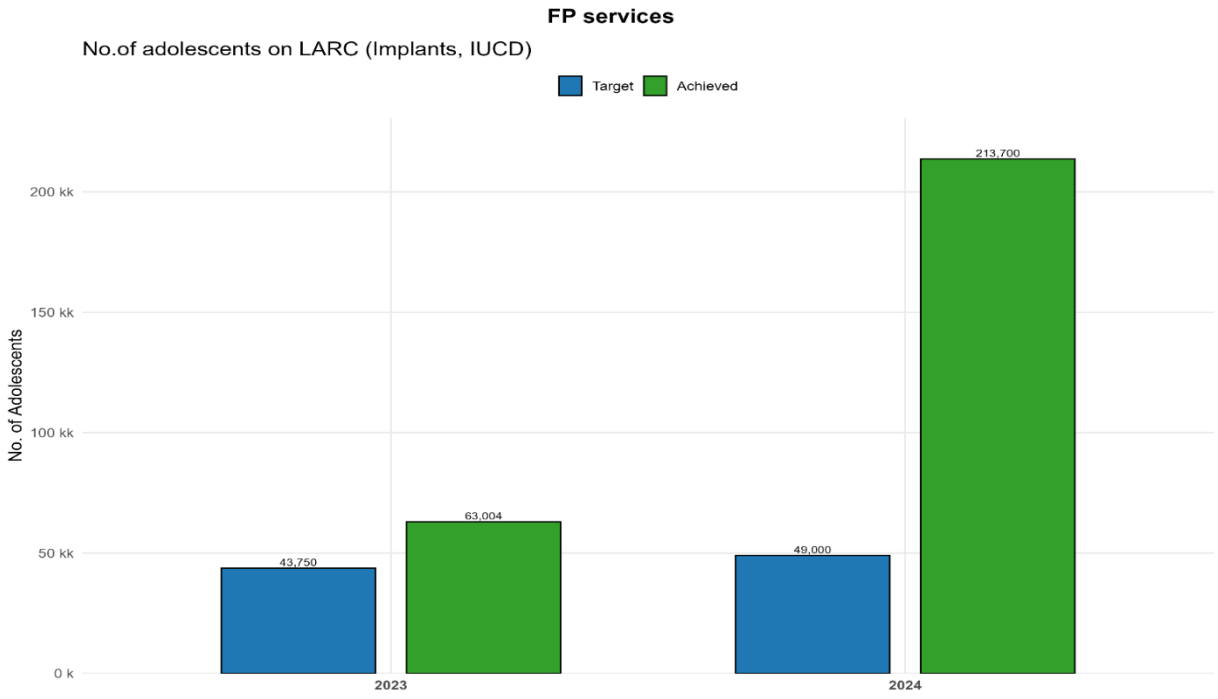

Figure 4: Number of adolescents on long-acting methods – 2023 & 2024 targets vs. results achieved

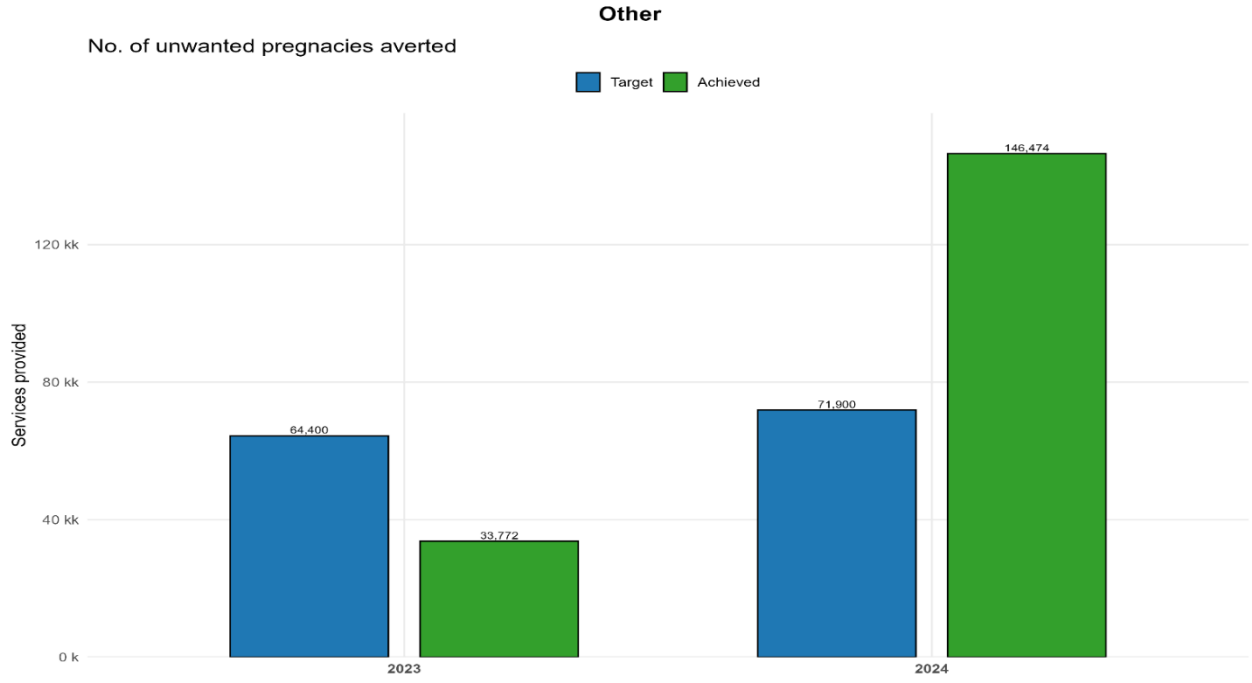

Figure 5: Number of unwanted pregnancies averted – 2023 & 2024 targets vs. results achieved

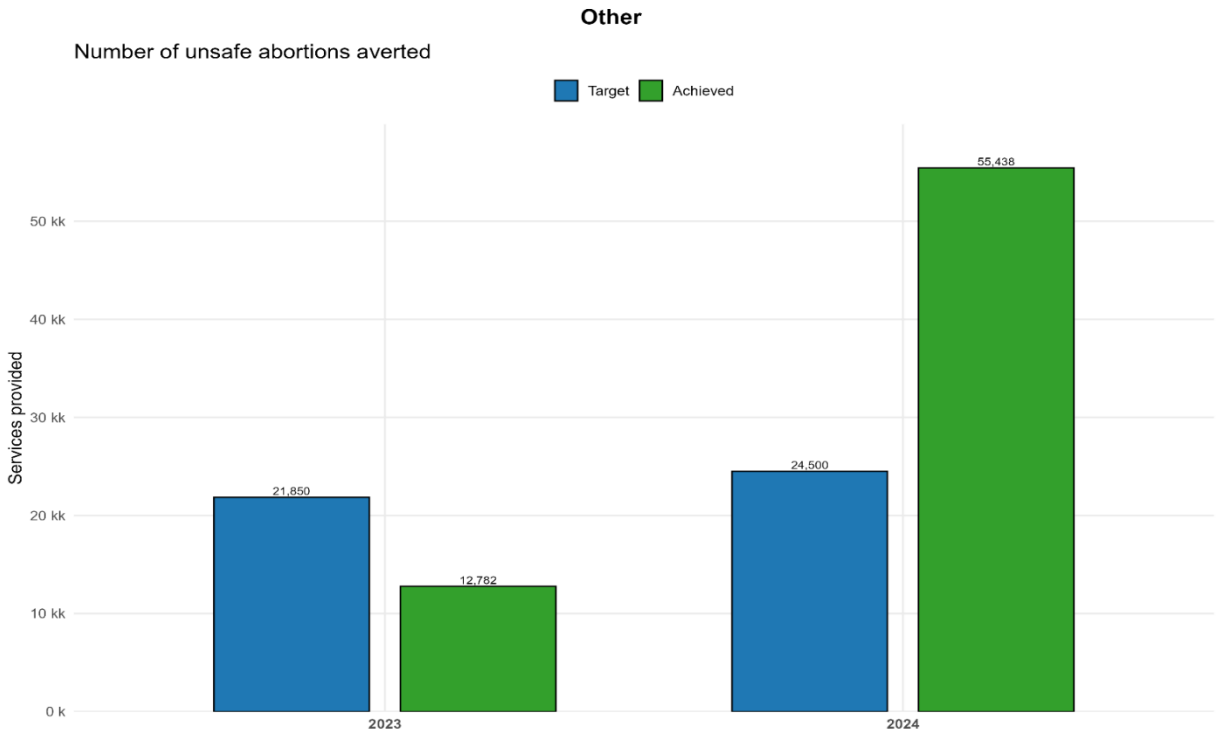

Figure 6: Number of unsafe abortions averted – 2023 & 2024 targets vs. results achieved

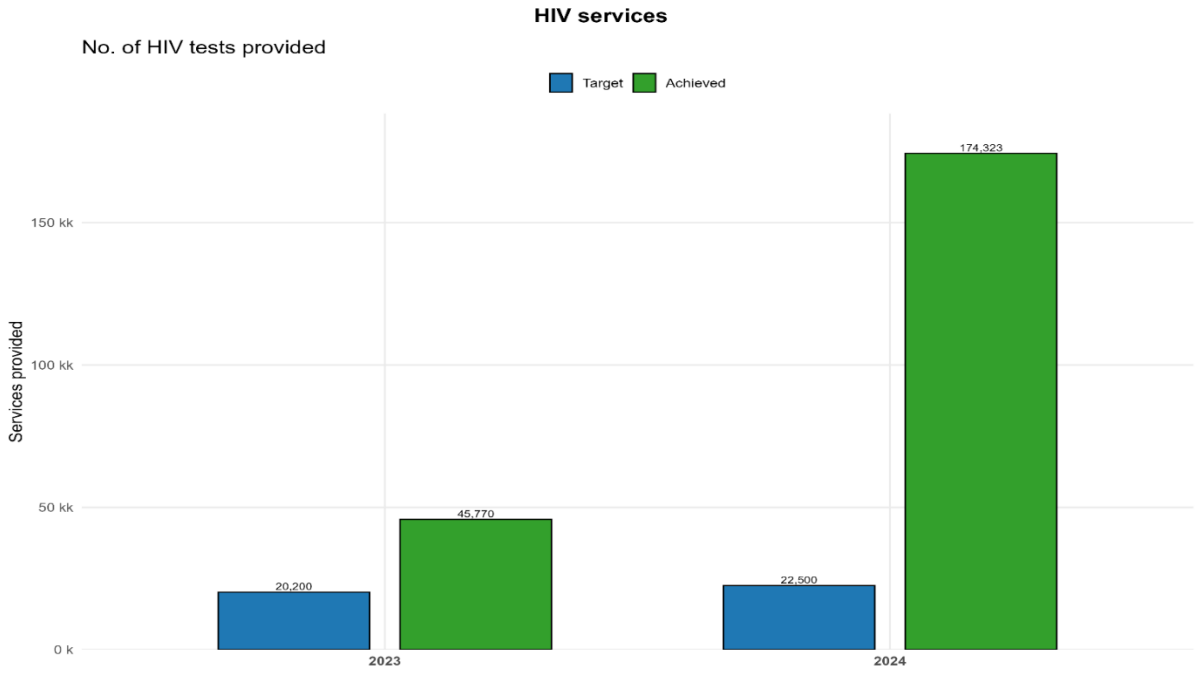

Figure 7: Number of HIV tests done by providers – 2023 & 2024 targets vs. results achieved

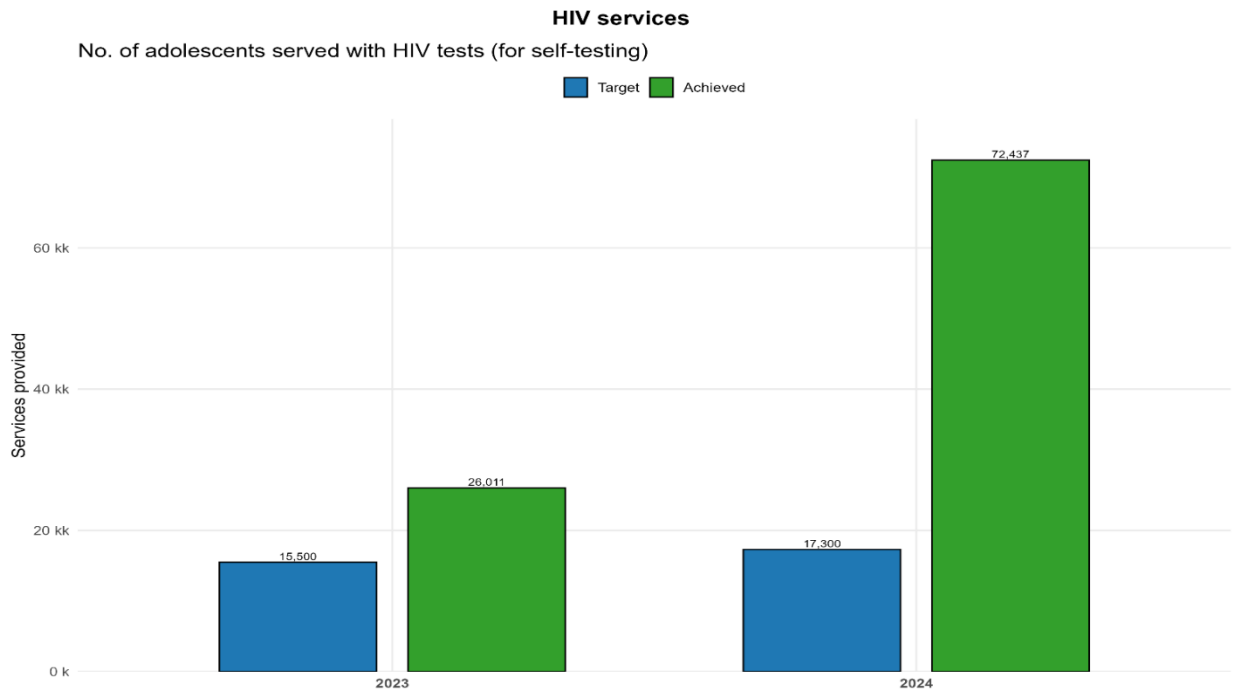

Figure 8: Number of HIV test kits issued for self-testing – 2023 & 2024 targets vs. results achieved

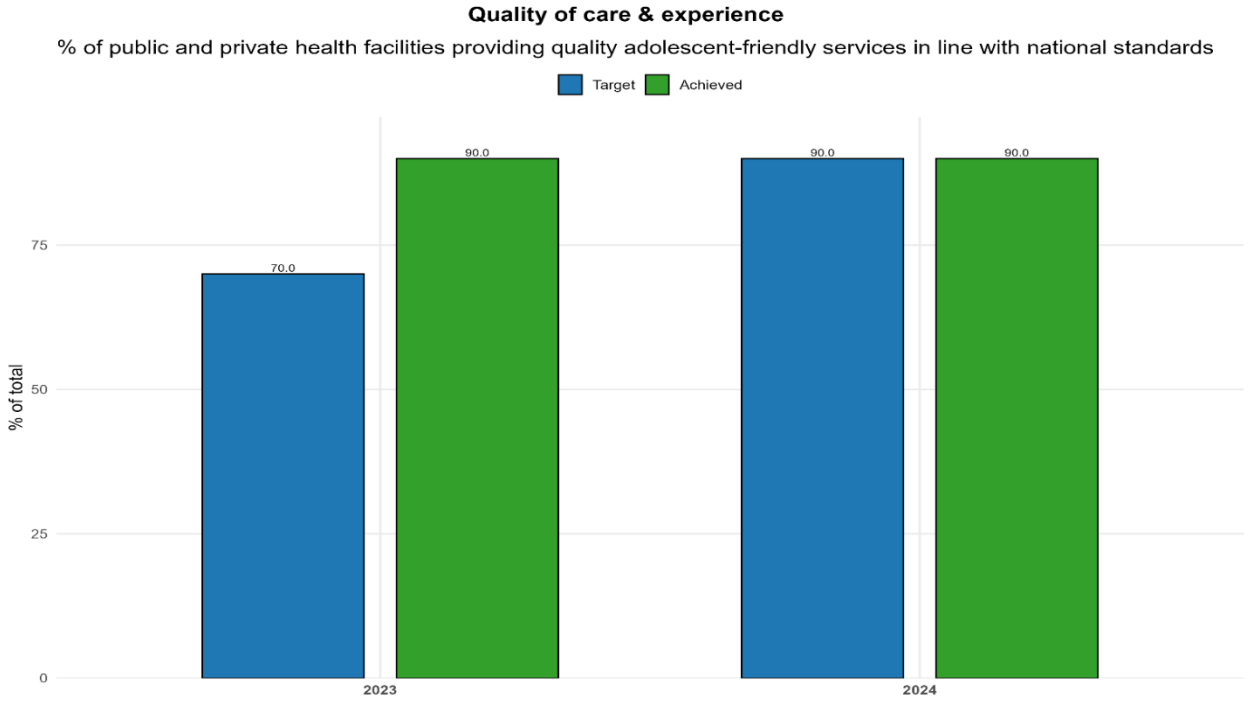

Figure 9: Percentage of public and private health facilities providing quality adolescent-friendly services - 2023 & 2024 targets vs. results achieved

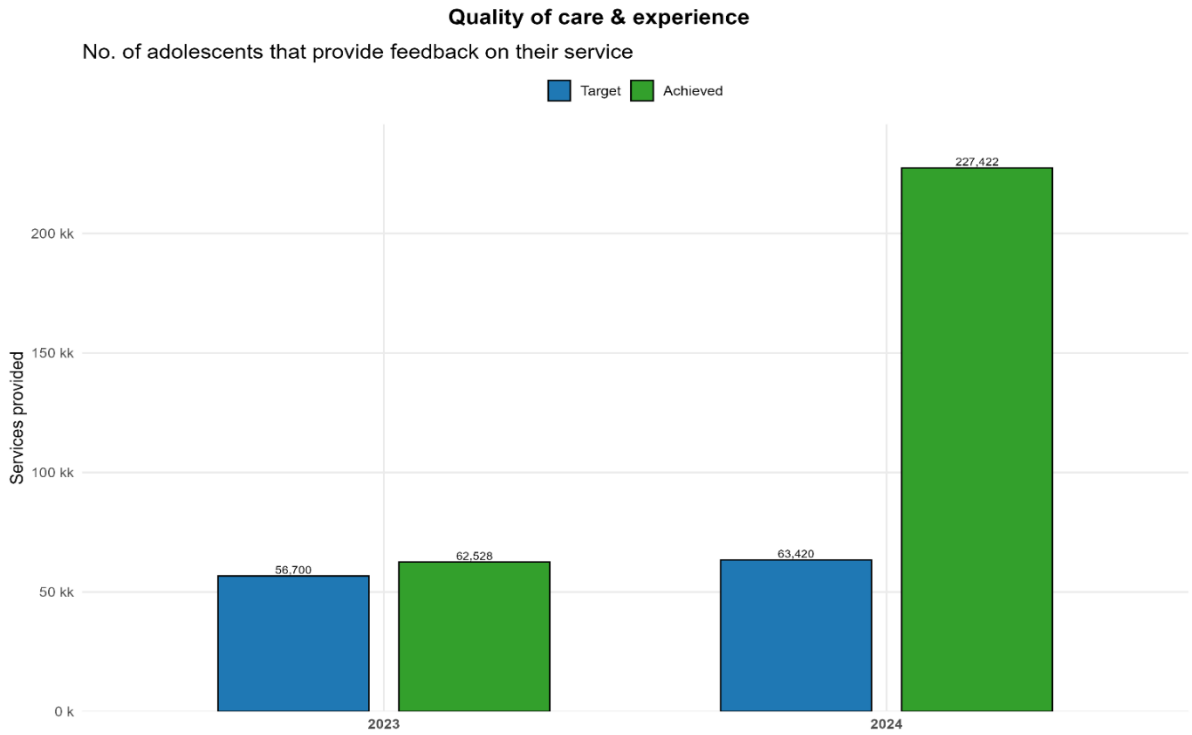

Figure 10: Number of adolescents that provide feedback on their services - 2023 & 2024 targets vs. results achieved

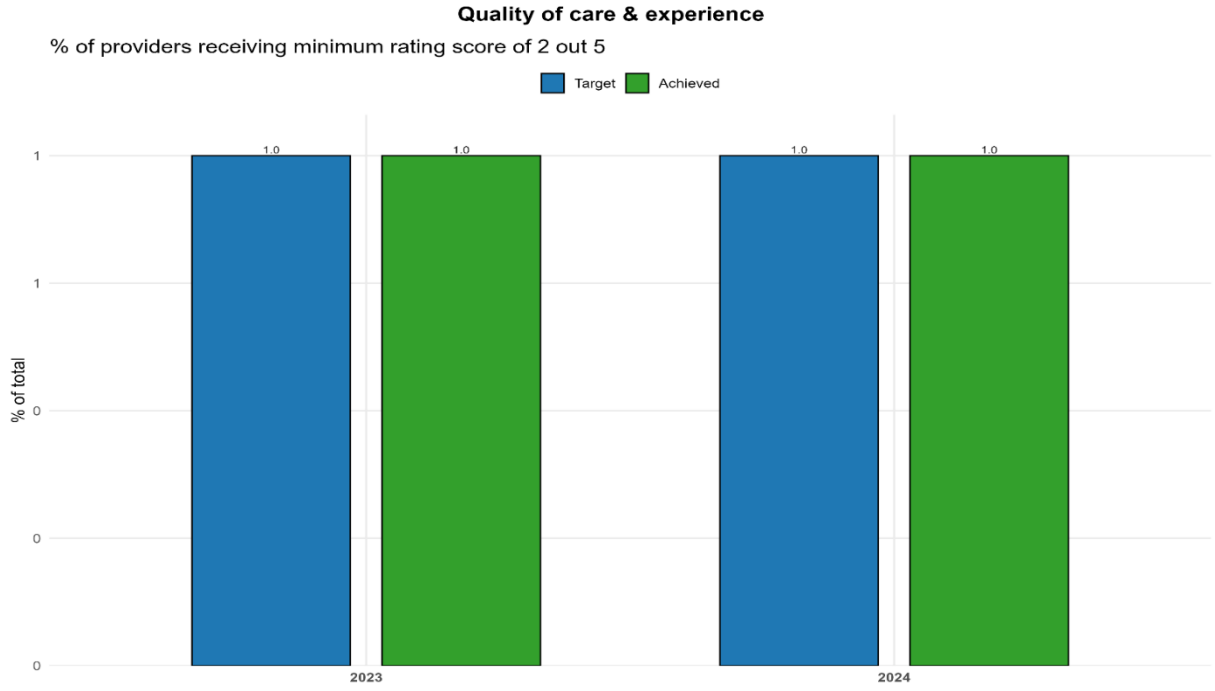

Figure 11: Percentage of providers receiving minimum rating score of 2 out of 5 - 2023 & 2024 targets vs. results achieved

- **Were the key results achieved against the results framework, especially in relation to outcome indicators and their end-of-project targets?**

  Yes. The majority of the outcome indicators have not only been met but also surpassed well ahead of the project timeline. Several factors contributed to this strong performance:

  - **Multi-sectoral collaboration:**
    - Close coordination between UN agencies (UNFPA, UNAIDS, WHO, UNRCO, SDGPP), county governments, investors, and implementers created a shared sense of accountability.
    - Technical and policy support from development partners strengthened service delivery and expanded advocacy reach.
  - **Alignment with government priorities:**
    - Strong alignment with Kenya's national agenda to end the "Triple Threat" (teenage pregnancy, new HIV infections, and sexual and gender-based violence).
    - This alignment increased political buy-in and facilitated integration of the DIB into county health priorities.
  - **Ownership and commitment by county administrations:**
    - Counties demonstrated ownership through onboarding of public health facilities into the program, active participation in quarterly review meetings, joint monitoring and supportive supervision, and contribution to data quality audits and performance reviews.
    - Though not quantified in monetary terms, county governments provided significant in-kind contributions such as payroll support for public facilities' staff, and administrative oversight.
  - **Inclusion of public health facilities:**
    - Unlike the earlier results-based program implemented by Tiko where implementation was limited to private facilities, the DIB successfully added public facilities**,** significantly expanding service access, especially for underserved populations in rural and peri-urban areas.
  - **Capacity building for healthcare providers:**
    - Training and mentorship improved providers' skills in adolescent-friendly SRH and HIV services.
    - Providers reported increased confidence in delivering sensitive SRH services to adolescents, improving both service quality and uptake.
  - **Robust data and monitoring systems:**
    - The Tiko platform provided real-time data that enabled quick course correction when underperformance was detected.
    - Data quality audits enhanced accountability and trust in the results, reassuring outcome funders and county stakeholders.
  - **Community mobilization and peer engagement:**
    - CBOs and trained mobilizers reached adolescents directly in schools and other community forums such as chief's barazas, markets and churches.
    - Peer champions amplified messaging and reduced stigma around service uptake, making services feel safer and more acceptable.
  - **Increased awareness and spillover benefits:**
    - Broad awareness campaigns and community dialogues increased the visibility of adolescent-friendly services.
    - This not only drove uptake among 15–19-year-olds but also among women above 19, creating positive spillover effects.
  - **Financial incentives across the service chain:**
    - Adolescent girls received small but meaningful rewards that encouraged uptake of services.
    - Mobilizers benefitted from incentives that motivated them to sustain outreach at the community level.
    - Healthcare providers and facilities received reimbursements, with many facilities reinvesting funds to strengthen ASRH/HIV services (e.g., installing Wi-Fi, renovating service provision areas, hiring extra HIV testing services providers).
  - **Flexibility and responsiveness of the DIB model:**
    - The DIB model's built-in flexibility enabled rapid adaptation to local needs. For example, in some counties such as Kisumu, data from the KHIS platform revealed service gaps in high-need areas. In response, county governments requested the onboarding of additional facilities in these locations to expand service coverage.
    - This responsiveness demonstrated how the DIB could adapt dynamically to evidence and county priorities, strengthening trust and ownership, and creating a culture of continuous improvement across partners.

- **What is the traffic light rating for progress across outcome areas?**
  Using a traffic-light coding system, overall, the program outcome areas are assessed as green, reflecting consistent achievement and, in many areas, exceeding of set targets.

  The only outcome area assessed as red/off-track relates to adolescent girls aged 15–19 years living with HIV who were successfully followed through to treatment. While HIV testing services and PrEP uptake have been prioritized and widely scaled, linkage to treatment for girls testing HIV-positive has lagged. Although this indicator (of girls aged 15 -19 years living with HIV and successfully followed through to treatment) was not quantitatively tracked, interviews revealed that many adolescent girls who tested positive were not successfully initiated on treatment. For example, a private provider described cases where girls referred to nearby public facilities for ART initiation never returned, nor sought services at the referral facility. This points to weak referral and follow-up systems, compounded by the program's primary focus on prevention and testing rather than sustained HIV care and treatment.

- **Does progress to date have potential for systemic change and/or demonstrative impact?**
  Yes. Progress to date has already demonstrated the potential to influence systemic change in several ways:
  - **Financing innovation:** The DIB has shown that performance-based financing can successfully drive outcomes in ASRH/HIV services, making it a potential model for other health financing mechanisms in Kenya.
  - **Strengthened multi-sectoral collaboration:** The joint implementation approach has strengthened working relationships between government, CBOs, private providers, and development partners. County health officials noted that lessons from the DIB are informing other areas, such as Social Health Authority (SHA) registration drives.
  - **Expanded reach:** The uptake of SRH services by women above 19 suggests a demonstrable effect, with benefits extending beyond the target population.

- **Have the financial solutions/instruments developed led to, or do they have the potential to lead to, developmental impact?**
  Yes. The DIB mechanism has already created demonstrable impact by:
  - **Improving access** to essential SRH services for adolescents and young women.
  - **Building capacity** within health facilities through training and digital service management.
  - **Stimulating accountability** through rigorous performance verification and linking financing to outcomes.

This model, if sustained, could accelerate progress towards SDGs related to health (SDG 3), gender equality (SDG 5), and partnerships (SDG 17).

- **To what extent can the solutions be scaled to other counties or sectors?**

  The model shows strong potential for scalability. Counties interviewed expressed interest in adopting similar performance-based financing arrangements for other priority health areas, including maternal health and HIV care. The main precondition for scaling is addressing the operational risks (e.g., staff turnover, technology disruptions, and commodity security). With these addressed, the model can be replicated in other counties and possibly in other sectors such as maternal health, nutrition or education.

- **What opportunities exist for the JP to benefit from the learning agenda?**
  The program has generated rich lessons through real-time data collection and field-based learning. These can inform best practices for:
  - **Technology adaptation** to address connectivity challenges and user experience issues.
  - **Provider support models** to mitigate service disruptions linked to staff turnover.
  - **Community mobilization approaches** that successfully engage both adolescents and older youth.

  Integrating these lessons into the broader SRHR and health financing agenda will enhance the replicability and sustainability of the approach.

- **What is the scope and scale of additional financing leveraged by the program?**

Although counties did not directly co-finance the DIB, their in-kind contributions are substantial. These include:
- **Administrative oversight** for both public and private health facilities.
- **Active participation** in quarterly review meetings, joint monitoring, supportive supervision, and data quality audits.
- **Procurement and distribution** of SRH/HIV commodities.
- **Payment of salaries** for healthcare providers in public health facilities.
- **Integration** of DIB-supported activities into CAWPs and CIDPs.

While not quantified during the MTR, these contributions significantly boosted program delivery and underscore the counties' commitment to ASRH/HIV services.

- **How has the program been able to unlock additional financing?**

  The ASRH-DIB has demonstrated strong potential to mobilize resources by blending traditional donor contributions with innovative financing and in-kind county support, while actively pursuing new partnerships with private, public, and impact investors to secure sustainable funding for adolescent health.

  - The program successfully attracted diversified financing beyond traditional donor sources, with outcome funding leveraging investments from multiple partners.
  - Although additional financing at county level was not in direct cash form, the program unlocked resources indirectly through public-sector support systems and increased community-level investments in health-seeking behaviors.
  - Based on the success of the current ASRH-DIB, the program has also been executing its fundraising strategy. To this end, pitch calls and follow-up engagement have been done with Equity Group Holdings, Grand Challenges Canada, CIFF's Impact Investment Team, the UBS Optimus-Bridges Outcomes Investment Fund, and NORAD.

- **How effective has the ASRH-DIB been in achieving its intended objectives?**

This section assesses the overall effectiveness of the ASRH-DIB in achieving its intended objectives, going beyond financial and output metrics to examine development impact, quality and relevance of service delivery, and observable or potential outcomes for the target population. The analysis draws on quantitative performance data, complemented by qualitative evidence from FGDs and KIIs in the 10 implementing counties.

Progress toward development impact

- The ASRH-DIB has demonstrated strong progress toward achieving its overarching goal of improving access to and utilization of quality ASRH and HIV services. Most key performance indicators have surpassed their midterm targets, illustrating the model's potential to deliver measurable, cost-effective, and scalable results.
- Beyond numerical achievement, the DIB has driven systemic change by embedding performance-based accountability within Kenya's health financing landscape. County officials noted that the model has strengthened data-driven decision-making, transparency, and collaboration across government, private sector, and civil society actors. By linking financing to outcomes, the DIB has incentivized efficiency and innovation, setting a precedent for results-based health financing in the country.
- Moreover, the program has enhanced health system capacity through training of service providers, establishment of digital service tracking mechanisms, and improved coordination across counties. These systemic shifts have reinforced Kenya's progress toward UHC and the national "End the Triple Threat" agenda.

Scope, quality, and relevance of service delivery

- Service delivery under the ASRH-DIB has been broad in scope and high in relevance to the needs of adolescents. The inclusion of both public and private facilities expanded geographic and socioeconomic reach, ensuring adolescents could access care closer to where they live and learn. The decision to onboard public facilities in significantly increased service equity and program coverage, especially for low-income girls.
- Quality of care has been strengthened through continuous provider training, supportive supervision, and mentorship. Many healthcare providers interviewed reported enhanced competence in delivering adolescent-friendly SRH and HIV testing services, including improved communication, privacy, and non-judgmental attitudes. Adolescent girls in FGDs described feeling "more respected and understood" when seeking services compared to before the program.
- At the same time, some operational challenges such as intermittent internet connectivity, difficulties with voice validation, and high staff turnover have occasionally affected service efficiency. However, the adaptive design of the DIB has allowed for rapid response, such as the development of rapid onboarding protocols and weekend platform access for school-going adolescents.

Observable and potential outcomes for the target population

- Evidence from fieldwork indicates tangible behavioral and social outcomes among adolescent girls. Mobilizers and providers reported increased demand for contraception, HIV testing, and follow-up visits, alongside reduced stigma around SRH service use. FGDs revealed a shift toward more informed decision-making, with many girls citing the Tiko platform as a trusted source of health information and a safe entry point for accessing services.
- In addition to improvements among the target 15–19-year cohort, the program generated positive spillover effects. Service data and county interviews indicate a notable rise in SRH service uptake among young women aged 20 – 24

years – an unintended but beneficial outcome attributed to increased awareness and normalized service-seeking behavior across communities.

- The DIB has also contributed to broader community outcomes. Mobilizers, some of whom are young people themselves, have emerged as influential health advocates. CBO involvement has strengthened community ownership, while county-level support supervision has improved coordination and accountability.

Overall effectiveness

- Overall, the ASRH-DIB has proven to be an effective and adaptive model for delivering adolescent health outcomes through innovative financing. It has not only met or exceeded most performance targets but also demonstrated tangible development impact through improved access, quality, and community engagement.
- The ASRH-DIB remains a high-performing and impactful program. Its lessons have far-reaching implications for the design of future results-based financing mechanisms in Kenya and beyond, especially in aligning adolescent health priorities with sustainable domestic financing pathways.

Management Efficiency

In this domain, the management efficiency was reviewed under three sub-domains, namely: management arrangements, reporting and communications. The following section lists the respective review questions under each sub-domain, followed by a detailed description of responses to the questions, based on the findings of the MTR.

Management Arrangements:

How was the overall efficiency of ASRH DIB management as outlined in the project document? Specifically:

- **Is there an ASRH-DIB governance body formally established with clear roles?**
  Yes. The ASRH-DIB operates under a formally established two-tier governance structure comprising the Steering Committee and Technical Committee.
  - The Steering Committee provides strategic guidance, oversight, advocacy, and resource mobilization, and is co-chaired by the Cabinet Secretary for Health and the Chair of the Health Committee at the Council of Governors (CoG), with membership including three of the UN Health Six Heads of Agencies (UNFPA, UNAIDS and WHO) and representative from the UNRCO.
  - The Technical Committee oversees service delivery, strategy execution, and resource mobilization. Membership includes technical staff from the JP partners, government partners (MoH and CoG), and representatives from the target implementation counties.

- **Is decision-making transparent and undertaken in a timely manner?**
  Partially. Decision-making during formal committee meetings is transparent, with minutes and follow-up actions documented. However, operational decisions especially those linked to payment flows face delays.
  - Healthcare providers especially those working in public health facilities reported occasional unexplained deductions from their earned Tiko miles.
  - Mobilizers in some counties also reported delays in receiving their reimbursements at the end of the set monthly reporting periods.

  These issues affect morale and continuity of service delivery, indicating a need for clearer communication and faster resolution of complaints related to financial matters.

- **Are responsibilities and reporting lines clear?**
  Yes, overall. The delineation of responsibilities between the UN Joint Team**,** Tiko**,** and government partners is clear in documentation. Reporting lines from the Steering Committee and Technical Committees are also well-defined.

- **Have changes been made and if so, have they been efficient?**
  Yes. A key avenue for these changes have been the quarterly review meetings convened by the Technical Committee. These meetings serve as a central coordination and performance management mechanism for the ASRH-DIB. They bring together representatives from all implementing counties, national program partners, Tiko and the UN Joint Team, providing a structured forum to:
  - **Track progress against targets**: Review performance data, verify achievement of results, and identify counties or facilities that require targeted technical or operational support.
  - **Share best practices and lessons learned**: Counties present successful approaches, innovations, and solutions to challenges, enabling peer learning and cross-county replication of effective strategies.
  - **Identify and address bottlenecks**: Open discussions allow for timely identification of challenges such as supply chain gaps, payment delays, or low uptake of specific services, and agreement on remedial actions.
  - **Strengthen accountability**: Counties publicly report on their progress, cultivating a culture of transparency and responsibility for meeting agreed targets under the project's performance framework.

- **Support adaptive management**: Emerging trends or contextual changes are discussed, allowing for adjustments in strategy, resource allocation, and implementation priorities.

Overall, quarterly review meetings are a critical enabler of the DIB's results-based financing model, ensuring that all implementing counties remain aligned to shared targets, informed by evidence, and committed to continuous improvement.

- **How effective is the UN Joint Team and Tiko in implementation?**
  - The UN Joint Team has been effective in providing technical guidance, aligning the program with UN priorities, and facilitating government and county engagement.
  - Tiko plays a central role in coordinating service delivery, managing implementing partners, and reporting data.

Both the UN Joint Team and Tiko have shown adaptability, but could strengthen joint problem-solving around payment delays and improve feedback loops with county implementers regarding financial transactions.

- **What is the quality of coordination and oversight provided by the UNRCO office?**
  - The UNRCO, through the SDGPP, provides strong high-level coordination, leveraging its convening power to engage senior government leaders, development partners, and the private sector. It plays a key role in catalyzing investments, mobilizing outcome funding, and managing the public image of the JP and the DIB.
  - Oversight quality is generally high, though there is scope for the UNRCO to further strengthen its mandate through improvements captured in the recommendations section.

Reporting:

- **How well do partners undertake and fulfil the ASRH-DIB reporting requirements?**
  - Overall, partners have demonstrated moderate-to-strong compliance with the ASRH-DIB's reporting requirements, submitting annual, midterm, and periodic updates in line with Joint SDG Fund guidelines. Most implementing partners have provided timely and complete service delivery, financial and results framework data, which the lead agent consolidates for submission to the SDG Fund Secretariat.
  - However, pharmacy reporting remains a notable gap**,** with incomplete or delayed reporting on contraceptive and HIV commodity distribution reported in several counties. This affects the accuracy of service uptake data.
- **How are results and lessons learned from the program documented, shared with key partners, and internalized by partners?**
  - Results and lessons learned are partially well-documented through quarterly review meetings, joint monitoring reports and annual progress reports. Quarterly review meetings, in particular, provide a platform for cross-county peer learning, with counties presenting innovations and problem-solving approaches.
  - Dissemination occurs through Steering Committee and Technical Committee meetings, UNRCO-led communications, and county-level debriefs, but the process remains largely ad hoc and dependent on meeting cycles.

Communications:

- **Was the ASRH-DIB communication strategy developed and if so, is it being followed?**
  - Yes. A comprehensive ASRH-DIB communication strategy was developed at inception, integrating branding, advocacy, and audience-specific messaging.
  - Implementation largely follows the strategy, with core messages on adolescent SRH rights, the DIB's innovative financing model and use of technology, and alignment with SDG 3 and 5 consistently reflected in communication outputs.
- **Do communications products reflect the "joint" nature of the program?**
  - Yes. Communication products such as letters, slide decks, event banners, and reports regularly feature the logos of UN Joint Program partners, donors, and implementing agencies, reinforcing the collaborative nature of the initiative.
  - However, a number of reviewed documents lack the Coat of Arms of the Government of Kenya despite the government being a key partner in the program. There is need to clarify whether this is by design or is an omission that needs to be managed.
- **Are there proper means of communication established or being established to inform the program's progress and intended impact to the stakeholders and the public at large?**
  - Multiple formal and informal communication channels exist, including: quarterly review meetings, stakeholder briefings, and social media updates, thus enabling timely information sharing on program progress and impact.
  - These are supplemented by targeted outreach through county forums and community-level engagements.
- **Have communications efforts been efficient and sufficient in order to inform the adolescent girls (program beneficiaries) on the new health and reproductive services available?**
  - CBOs and community mobilizers have been instrumental in sensitizing adolescent girls on available SRH and HIV services, particularly through peer-led sessions, health facility in-reach, and school and community outreach.

- However, reach and consistency vary by county, with urban areas benefiting from stronger mobilization efforts compared to rural and remote settings.

- **Are there gaps in communications and visibility of the program that the joint team could galvanize and leverage on their existing structures and mechanism to address in order to improve quality and adolescent friendly services?**
  A situational analysis of the communications strategy revealed a number of existing **strengths and opportunities** that are already in place:
  - The program has leveraged high-profile national and global platforms to showcase its success, positioning the ASRH-DIB as both a pioneer in outcomes-based financing and a technology-driven public health initiative. These platforms include:
    - **Homabay County International Investment Conference (Homabay, February 2024):** CoG and SDGPP participated in a session on *"Leveraging Public-Private Partnerships to Increase Investments in Health."*
    - **African Venture Philanthropy Alliance Conference (Nairobi, November 2024):** Tiko, UNFPA, and CIFF presented on *"From Innovation to Institutionalization – Mainstreaming Outcomes-Based Financing."*
    - **Global Digital Health Forum (Nairobi, December 2024):** Tiko held a session on *"Artificial Intelligence and Machine Learning – Achieving Public Health Outcomes Through Innovative Technology."*
    - **UN General Assembly (September 2024):** Tiko and SDGPP Kenya co-hosted a side event on *"Financing the Uncertain Future of SRHR in a Multi-Crisis World – Exploring Models for Protecting SRHR in Sub-Saharan Africa."*
    - **2024 Global AIDS update by UNAIDS: The ASRH-DIB was featured as a success story under the title, "**

  - County governments, CBOs, and mobilizers are already embedded in implementation and could be further engaged as amplifiers of success stories at the community level.

  The situational analysis identified the following **gaps**:
  - **Post-launch social media lull**: The ASRH-DIB experienced a surge in visibility during its launch period (second half of 2023), particularly on social media platforms such as X. However, this momentum has not been consistently sustained. A noticeable decline in online engagement followed the launch phase, with fewer regular updates, success stories, or program milestones being shared thereafter.
  - **Limited event amplification**: While the program has participated in important forums, the visibility gains from these events have not been fully maximized through post-event content sharing, media engagement, or policy-oriented outputs.
  - **Insufficient adolescent-led digital advocacy and storytelling:** Focus group discussions revealed that adolescent girls want greater involvement – not just as users but also peer champions, in sharing their lived experiences and leading digital campaigns, so as to make communications more relatable, engaging, and relevant to their peers.
  - **Learning agenda outputs not fully linked to communications**: Knowledge products such as policy briefs, infographics are likely under-prepared and under-shared, limiting the program's thought leadership profile.

Risk Management

The following section lists the respective review questions under the risk management criterion, followed by a detailed description of responses to the questions, based on the findings of the MTR.

- **Were the risks identified in the project document and annual reports the most important, and are the risk ratings applied appropriate and up to date?**
  - The risks identified in the project document and annual reports such as commodity shortages, quality of care concerns, political opposition, and outcome funding shortfalls, remain the most relevant threats to program success.
  - Risk ratings generally align with the operational reality. For example, donated SRH commodity shortages are appropriately rated as high risk (Certain likelihood 5 * Major impact 4 = 20) given confirmed donor funding cuts.

Updating of risk ratings:
The foregoing notwithstanding, some risk ratings may require updating:

- **Contextual risks:** With changing times, these need updating. For example:
  - Covid-19 restrictions may be less relevant in 2025 with the pandemic now under control.
  - Greater risk now may be from frequent health worker strikes, or new public health crises such as the current sporadic outbreaks of Mpox in various parts of the country.

- **Fraud and corruption risks:** These were previously assessed as (Likely likelihood 4 * Minor impact 2 = 8), and may have been underestimated based on various findings from fieldwork:
  - County government officials in some counties noted that a number of facilities were blacklisted following verification processes that uncovered falsification of data aimed at increasing claims for incentives.
  - Healthcare providers in some public health facilities decried the lack of transparency in the way reimbursements to the facilities were utilized, and lack of reinvestment of the funds to support ASRH/HIV services despite their being obvious areas that needed strengthening.
- **Technology risks:** These were rated as (Unlikely likelihood 2 * Major impact 4 = 8) and may also need upward revision. Feedback from healthcare providers revealed operational challenges that heighten this risk:
  - **Connectivity gaps:** Several providers reported lack of internet connectivity in their facilities, forcing them to use their own airtime to access the Tiko platform. This creates a disincentive for timely data entry and may delay service validation.
  - **Voice validation issues:** The voice validation function used to confirm service delivery was cited as unreliable, with frequent failures that required multiple attempts, leading to frustration among providers and adolescent girls, to the extent of services not being captured on the Tiko platform at all, which in turn dampened the morale of the users.
  - **Weekend service access constraints:** Because school-going girls often access services over weekends, some providers reported difficulty accessing the Tiko platform on Saturdays and Sundays**,** with system downtime or restrictive processes to enable weekend access. The procedures for activating weekend system use were described as difficult and time-consuming, occasionally resulting in missed or delayed service logging.
- **Are there other emerging risks that may jeopardize the sustainability of ASRH-DIB outcomes?**
  Yes. In addition to the risks identified in the original risk management plan, the MTR showed new and evolving risks that require integration into the updated risk management plan to ensure proactive mitigation and sustained program impact. These include:
  - **Legal and policy environment risks:** The evolving legal and policy context poses a significant threat to the continuity and equity of ASRH service provision. While the 2015 ASRH Policy affirms adolescents' rights to access SRH services without unnecessary barriers, the National Reproductive Health Policy 2022–2032 introduces restrictive provisions such as parental consent requirements and the exclusion of unmarried adolescents and marginalized populations, provisions that infringe upon privacy, autonomy, and the constitutional guarantee of the right to health under Article 43(1)(a) of the Constitution of Kenya, 2010. These restrictions have the potential to reverse gains made by the DIB in ASRH service uptake. The 2022 Policy is currently under legal challenge in the High Court of Kenya (Petition No. 027 of 2022, Nairobi) for reasons including lack of public participation and discriminatory provisions.

    Interviews with providers revealed that this scenario places them in a legally uncertain position when it comes to provision of ASRH services. These findings were echoed by the county officials with one of them stating that there was a situation where a parent had sued a provider and a facility for providing a LARC method to their daughter, with the case currently in court. In practice, many providers circumvent these restrictions by invoking constitutional guarantees, particularly Article 43(1)(a), which enshrines the right to the highest attainable standard of health, including reproductive health care. While this ensures service continuity, program stability could be undermined if parents/guardians take legal action against providers and facilities, and if the anticipated High Court ruling upholds restrictive policy provisions.

    High staff turnover risk: Although this was not factored in the risk management plan, interviews with most county officials showed that high turnover of providers in public health facilities due to routine county-level staff transfers posed a risk to program implementation. While Tiko has demonstrated commendable responsiveness in training and onboarding incoming staff, the process takes time and incurs additional costs. These delays result in missed service provision opportunities for adolescent girls, and may reduce the program's efficiency in the short term.
- **Have there been unintended positive or negative effects observed as a result of the ASRH-DIB interventions?**
  Yes. The ASRH-DIB has yielded a mix of positive and negative effects beyond its initial design parameters.
  - **Positive effects include:**
    - **Expanded uptake beyond target cohort**: While the program's primary focus is adolescent girls aged 15–19, service delivery data and interviews with county officials and healthcare providers revealed an unintended but beneficial increase in the uptake of SRH services by women aged 20 years and above. This may be linked to the

broader awareness campaigns, CBO-led mobilization activities, and the visibility of adolescent-friendly services that also appeal to young women just outside the target group.

- **Strengthened multi-sectoral collaboration**: The joint implementation model has strengthened working relationships between government, private providers, and CBOs, extending beyond ASRH to other health initiatives, as reported by county health officials. For instance, the CBOs have played a key role in mobilizing community members to register with the SHA which is currently a key performance area for county governments.
- **Enhanced capacity in digital health platforms**: Training on the Tiko platform has equipped healthcare workers with digital service management skills that they can apply to other health programs, thus improving efficiency in patient flow and record-keeping.

- **Negative effects include:**
  - **Incidents of fraudulent activity**: While relatively limited, some providers engaged in fraudulent claims, resulting in termination of contracts. Though addressed through strengthened verification and monitoring, these incidents disrupted service access in the affected areas.
  - **Technology access barriers**: Connectivity issues, weekend platform access limitations, and voice validation challenges have occasionally hindered timely service provision.
  - **Service gaps from staff turnover**: Frequent transfers of trained public facility staff have led to temporary service delivery disruptions and incurred additional costs for retraining and onboarding new personnel.

Sustainability and Exit Strategy

The following responses to the review questions under the sustainability and exit strategy criterion are grounded in findings from the MTR, and highlight both the progress made and the persistent challenges in embedding the ASRH-DIB model within Kenya's health systems so as to ensure sustainability.

- **How likely is it that the financial instruments (including the ASRH-DIB) will remain viable once the program ends?**
  - The likelihood of sustaining the ASRH-DIB's financial instruments after program completion is moderate. While ten counties have already committed to co-financing public sector delivery, these commitments are not yet fully embedded in long-term budget frameworks and may be vulnerable to shifting priorities.
  - Some counties such as Bungoma have ring-fenced funds toward AYSRH and will continue to engage Tiko as an output co-payer using the DIB model. Three more counties are also designing strategies to continue providing ASRH services using a model similar to that of the DIB.
  - Reliance on donor-driven outcome funding remains high, with limited diversification of funding streams beyond current investors. National and county government officials stressed that budgetary pressures remain a significant risk.
  - They further noted that sustained financing will depend heavily on National Treasury allocations, the SHA reimbursements, and continued donor bridging support.

- **To what extent have relevant public and private sector partners (on both the demand and supply sides) demonstrated commitment to sustaining the financial instruments and program activities?**
  - There is evidence of strong national-level policy alignment, particularly through the government-chaired steering committee and integration with existing ASRH and HIV service delivery frameworks such as the commitment to end "The Triple Threat".
  - County health officials also reported strong ownership of the ASRH-DIB model, highlighting alignment with county SRHR priorities and inclusion in the CAWPs and CIDPs. Additionally, county health officials expressed willingness to maintain program activities, but stressed the need for continued technical and financial support, particularly for sustaining the Tiko platform and incentive mechanisms.
  - Buy-in from the private sector is strong, although most private facilities cited uncertainty about continuity of services post the ASRH-DIB since adolescents would have to pay for services themselves or rely on SHA if reimbursements for ASRH/HIV services will be covered under SHA.
  - CBOs and mobilizers also confirmed their commitment to continuing adolescent engagement. Most mobilizers expressed a desire to be on-boarded as community health promoters (CHPs) within the government's primary healthcare system so as to continue supporting adolescent-engagement post the ASRH-DIB.

- **What is the likelihood that the program's actions, service delivery models, and results will be maintained by local partners and stakeholders after external funding ends?**
  The likelihood of sustaining the ASRH-DIB's actions, service delivery and results post-program is moderate, as evidenced by these findings:

- County governments have incorporated some ASRH DIB-driven mobilization strategies into their broader health outreach activities, such as mobilizing community members to register with SHA, suggesting potential for continuity.
- Healthcare providers and mobilizers highlighted that skills acquired such as digital health training on Tiko and adolescent-responsive counseling, are transferrable to other health initiatives such as those addressing mental health issues.
- Adolescent girls in FGDs expressed that the peer-friendly and non-judgmental services should be sustained beyond the DIB, and be used to address other health concerns such as mental health issues.

- **Has the joint program developed and leveraged the necessary public–private and development partnerships to sustain results?**
  - The joint program has cultivated strong partnerships across government, development partners, CBOs, and private providers. These partnerships have already extended beyond ASRH into areas such as SHA registration drives.
  - However, private sector engagement in long-term sustainability planning remains limited, and there is an opportunity to leverage private sector networks (e.g., more pharmacies, insurers) to bolster sustainability.

- **What critical enablers or barriers could influence the sustainability, scaling, or replication of program outcomes in other counties or contexts?**
  - Key enablers include the proven multi-sectoral delivery model, strong community mobilization through CBOs, provision of adolescent-friendly services, and integration of services into existing county health systems.
  - Barriers include over-reliance on donor commodity supplies, and limited capacity for continuous provider training amidst high staff turnover.

- **Based on phase 1 successes, challenges, and lessons learned, how feasible is it to proceed with a phase 2 of the ASRH-DIB?**
  - Stakeholders at both national and county levels overwhelmingly supported a second phase, citing the ASRH-DIB's successes in mobilizing adolescents and strengthening service delivery.
  - Suggested adjustments for a second phase include improving the design, strengthening the management efficiency, communications strategy and risk management of the DIB, as discussed later in the recommendations section.

- **Does the joint program have a realistic, clearly defined, and feasible exit strategy, including a pathway for the transfer of responsibilities to local stakeholders?**
  - The joint program has not yet articulated a fully detailed exit strategy. While there is an intention to transition responsibilities to county governments and CBOs, specific timelines, financing arrangements, and capacity-building milestones are still under development.
  - County health officials stressed the importance of early planning for the phase-out of external incentives, to avoid sudden service uptake declines.
  - Noteworthy, Tiko continues to operate at scale in the implementation counties through other donors though the ideal long-term strategy is to have the counties co-finance ASRH programs.

Conclusion and Recommendations

Conclusion

The MTR of the ASRH-DIB demonstrates that the program is well-designed, delivering results beyond initial targets, and continues to present valuable lessons for health financing innovations in Kenya. The findings highlight both strong progress and persistent challenges, with clear implications for sustainability and scale-up.

Design: The design of the ASRH-DIB was found to be both relevant and innovative. By combining financial incentives with capacity building, data-driven monitoring, and strong alignment with national and county priorities (particularly the "Triple Threat" agenda), the model has achieved strong buy-in from key stakeholders. The inclusion of both public and private health facilities significantly broadened service reach compared to the earlier Tiko project that worked with private health facilities only. However, design gaps such as exclusion of adolescent boys and young men, adolescent girls aged 10-14 years and young women aged 20-24 despite their particular vulnerabilities, emerged. Use of voice for identity validation also inadvertently excluded adolescent girls with speaking and/or hearing disabilities.

Results/Progress to Date: The program has surpassed most of its outcome targets, including uptake of SRH and HIV services, mobilization of adolescent girls, and strengthening of facility capacities. This success can be attributed to multiple factors: financial incentives for adolescent girls, mobilizers, and providers; county ownership, joint field monitoring and support supervision; and effective community engagement. A key shortfall, however, lies in the continuum of care for adolescent girls living with HIV, where linkages to treatment remain weak. Strengthening patient navigation, particularly through mobilizers, is essential to close this gap.

Management Efficiency: Program management has been generally efficient, with adaptive practices evident in the onboarding of additional facilities where data revealed service gaps. Joint reviews and data audits promoted transparency and accountability. Nonetheless, some operational inefficiencies persist, particularly in relation to Tiko platform functionality (e.g., voice validation and weekend access issues), which strain provider morale and risk service disruptions. Additionally, there were challenges with lack of transparency and clear structures in the utilization of funds from the facility incentives program in public health facilities.

Risk Management: The risk management framework has largely remained relevant, but the MTR revealed areas that need updating. Fraud and corruption risks were likely underestimated, as evidenced by facilities blacklisted for falsifying claims. Technology risks proved more severe than initially rated, with system downtime, voice validation and connectivity challenges affecting service delivery. Emerging risks include the restrictive provisions of the 2022 National Reproductive Health Policy and high staff turnover in public facilities due to attrition and transfers. Both require stronger, proactive mitigation strategies to safeguard program continuity.

Sustainability and Exit Strategy: Sustainability prospects are promising but not yet guaranteed. While counties did not contribute direct co-financing, their in-kind contributions such as payroll support, administrative oversight, and supervision were substantial and critical to program success. The DIB has also attracted interest from diverse partners, laying a foundation for resource diversification. Yet, heavy reliance on external outcome funding remains a vulnerability. A stronger, clearly articulated exit strategy anchored in county ownership, domestic financing, and integration of services, will be key for long-term impact and potential scale-up.

Recommendations

Building on the findings of the midterm review, this section outlines targeted recommendations to strengthen the ASRH-DIB across five key review criteria: Design, Progress and Results, Management Efficiency, Risk Management, and Sustainability**.** Together, they aim to enhance the inclusiveness and effectiveness of service delivery, optimize program management and communication, anticipate and mitigate risks, and secure long-term gains through strengthened systems and community ownership.

To strengthen usability of the recommendations, these have further been synthesized into a matrix categorizing them as short, medium- and long-term with indicative timelines and responsible actors. Please see Annex 3.0: ASRH-DIB Recommendations Matrix.

Design

Adopt alternative means to voice identity validation:

- Adopt alternative, non-discriminatory identity validation methods. One option is to incorporate finger-based scanners that do not store actual fingerprint images but instead convert them into irreversible, encrypted alphanumeric templates (hash codes). These templates cannot be used to reconstruct the fingerprint, thus meeting privacy and data protection standards as per the Kenyan law and global standards on data protection.
- For users uncomfortable with biometric data, provide manual PIN or QR-code–based verification options.
- Overall, clearly communicate privacy safeguards to build trust in the system, and train service providers on disability-inclusive service protocols.

Include adolescent girls aged 10 – 14 years and young women aged 20 -24 years:

- For adolescents aged 10-14 years, develop an age-appropriate service package that prioritizes age-appropriate education, prevention, protection, and psychosocial support, without normalizing early sexual activity.
- Extend program eligibility to cover young women aged 20–24 years, with services tailored to their life stage to ensure uninterrupted service use during high-risk years. Particularly, introduce the program in TVETs, colleges and universities to serve adolescent girls and young women transitioning to adulthood.

Include adolescent boys and young men:

- Integrate male-focused SRH and HIV education sessions into community outreach.
- Provide adolescent-friendly services for boys and young men in both public and private facilities.
- Design couple-based or peer-to-peer interventions that promote shared responsibility in SRH and HIV prevention.
- Engage male role models and community leaders to challenge harmful gender norms.

Broaden package of services to cover intersecting vulnerabilities and co-occurring conditions:

- Provide services to address GBV, including prevention, screening, response, and referral mechanisms for survivors, to strengthen Kenya's response to the "Triple Threat".
- Offer STI services covering routine screening, diagnosis, treatment, contact tracing and education, to reduce transmission and reinfection.
- Introduce cervical cancer prevention efforts encompassing screening, and strengthening promotion and delivery of the HPV vaccine, as a critical preventive intervention.
- Onboard partners through corporate social responsibility initiatives to provide sanitary pads for adolescent girls.
- Integrate mental health services including screening, counselling, psychosocial support, and referral linkages.

Adjust, harmonize and standardize Tiko miles:

- For adolescent girls, increase from 40 to 80-100 miles per service, to enable girls to redeem pads consistently.
- For mobilizers, harmonize to 125 miles per enrollment, regardless of method, thus balancing program equity with digital adoption goals.
- For public healthcare providers, increase 20 miles to within the range of 50-75 miles per service, to balance provider effort with program sustainability.
- For private healthcare providers, introduce 50-75 miles per service to match what is proposed for public providers, to enhance equity, strengthen morale, and ensure quality service delivery and accountability across all types of facilities.
- For all in the Tiko miles chain, consider incremental adjustments, coupled with other incentives such as recognition certificates and conference sponsorships.

Progress/Results

Support girls testing positive for HIV to ensure linkage to care and treatment:

- Strengthen referral and linkage systems between private and public facilities, with clear accountability mechanisms to ensure that girls who test positive are enrolled in care.
- Work with mobilizers and young peer providers as patient navigators to accompany girls to referral facilities, provide psychosocial support, and follow up on treatment initiation and adherence.
- Where possible, integrate service delivery by exploring opportunities for initiating ART directly at facilities providing HTS (including private facilities), to reduce the risk of drop-offs during referral.
- Strengthen adolescent-friendly ART services in ART services in public facilities, ensuring confidentiality, stigma-free care, and flexible hours (e.g., weekend or after-school access).
- Improve data tracking within the Tiko platform to flag girls who test positive and follow their linkage to treatment, with feedback loops to providers and mobilizers to close gaps.

Management Efficiency

Improve coordination by UNRCO office:

- Expand domestic resource mobilization efforts by broadening investment outreach to include local private sector actors, philanthropic organizations, and high-net-worth individuals in Kenya; and develop tailored investment pitches demonstrating the DIB's return on investment in terms of social impact, economic benefits, and alignment with Kenya's UHC and "End the Triple Threat" agenda.
- Enhance real-time communication and visibility by increasing the frequency and diversity of public updates (social media, press briefings, community radio) on DIB progress and impact stories; and showcase county-level successes to build political and community buy-in while reinforcing the DIB's credibility with funders.
- Leverage the UNRCO's convening power to mediate and resolve operational issues, such as payment delays, by facilitating rapid decision-making between UN agencies, Tiko, government partners and providers.
- Explore blended finance approaches, combining grants, concessional loans, and impact investments, to reduce reliance on a narrow pool of donors especially with the recent and ongoing cuts in global health financing; and position the DIB as a flagship case study in regional and global UN forums to attract new funding streams.
- Continue ensuring that the DIB is framed as a vehicle for achieving Kenya's UNSDCF and UHC targets and the "End the Triple Threat" commitment, thereby maximizing political and financial support.

Enhance documentation, internalization and dissemination of lessons learned:

- Develop a centralized knowledge repository accessible to all partners.
- Produce regular learning briefs summarizing innovations, challenges, and scalable approaches.
- Embed lesson-reflection sessions in quarterly review meetings, with structured follow-up to ensure that agreed improvements are implemented at county level.
- Produce policy briefs to inform adoption of innovations in other counties, countries for scaling up; and other sectors for replication.
- Publish peer-reviewed articles in scientific journals to increase program visibility in academia and research, and showcase the thought leadership of the program.

Strengthen reporting by private facilities and pharmacies:

- Provide training, clear reporting templates, mentorship and support supervision to providers, to ensure data on SRH/HIV services are properly captured and fed into the KHIS.

Strengthen the communications strategy:

- Reignite social media momentum by developing and maintaining a content calendar with monthly updates on program achievements, human-interest stories, and service uptake data. Also, tag partners and donors to widen reach.
- For every high-profile engagement (e.g., AVPA, Global Digital Health Forum, UNGA), create pre-event teasers, live updates, and post-event summaries with photos, quotes, and key takeaways for circulation on social media, websites, and newsletters.
- Empower county-level champions by equipping county governments, CBOs, mobilizers and adolescents with branded communications kits (templates, fact sheets, key messages) to facilitate localized storytelling. Invite representations from county governments, civil society, and youth ambassadors to co-present findings or co-host sessions at upcoming conferences like AVPA (November 2025, Nairobi).
- Scale adolescent-led campaigns by supporting adolescent girls and peer educators to produce and post short videos, testimonials etc. on SRH/HIV topics under a recognizable campaign hashtag (e.g., #MyFutureMyChoice).
- Link the learning agenda to visibility by publishing research briefs, case studies, and infographics from program data and presenting them at sector events such as upcoming Devolution Conference 2026.
- Strengthen partner coordination by using quarterly review meetings to align on joint communication priorities, upcoming events, and synchronized messaging to maintain the "joint" nature of branding.

Risk Management

Update the risk management plan:

- Revise outdated risks (e.g., COVID-19 restrictions) to reflect emerging threats such as health worker strikes, sporadic Mpox outbreaks, and inflationary pressures.
- Elevate risk ratings for fraud/corruption and technology-related barriers to align with field realities.
- Incorporate high staff turnover as a formal programmatic risk, with mitigation strategies to reduce service disruption during transitions.

Strengthen fraud and corruption prevention:

- Build on existing verification processes by introducing predictive analytics to flag anomalies in real time.
- Institute transparent and documented utilization of reimbursements at public facilities, through the leadership of county health management teams, with support from other program partners.
- Provide targeted training on ethical claims processing for all newly on-boarded providers.
- Grant CHMTs relevant access to the Tiko data dashboard to enable them monitor progress in their counties, and institute corrective action where incidences of data falsification are suspected.

Address technology barriers proactively:

- Utilize part of the reimbursements in public health facilities to install and pay for stable internet to support provision of ASRH/HIV services.
- Consider alternative means of validation other than voice e.g. finger-based scanners that do not store raw fingerprint images but generate encrypted, irreversible alphanumeric templates.
- Automate weekend access for the Tiko platform to align with peak service demand from school-going girls, reducing reliance on cumbersome manual activation requests and authorizations.

Address legal and policy framework risks:

- Continue leveraging the 2010 Constitution as the supreme legal framework to guide service delivery.
- Strengthen advocacy efforts with MoH, Parliament, and civil society to push for alignment of the 2022 Policy with constitutional guarantees and international human rights standards.
- Engage legal aid and human rights organizations to support providers and adolescents navigating policy-related barriers.
- Maintain close monitoring of the High Court petition outcome and adapt programming accordingly.

Mitigate high staff turnover:

- Develop a rapid response onboarding toolkit (digital and in-person) to train incoming staff within 48 – 72 hours of transfer.
- Explore training-of-trainers' models so that counties maintain a pool of trained mentors to cascade skills locally.

Leverage unintended positive outcomes:

- Expand awareness and service access strategies that have driven increased uptake among women above 19, without diluting the adolescent focus.
- Use this expanded demand as an entry point for family-based and community-level interventions to normalize SRH discussions.

Sustainability and Exit Strategy

Secure predictable financing through domestic systems:

- Utilize the convening power of the UN agencies to strengthen advocacy at National Treasury and county levels for ASRH/HIV budget lines.
- Provide budgetary resources at the county level to support ASRH/HIV services as embedded in the CAWPs and CIDPs.
- Improve transparency in use of facility improvement funds, with visible re-investment in ASRH/HIV service delivery such as procurement of commodities, provision of internet connectivity and infrastructural improvement.
- Develop a clear, time-bound roadmap for integrating ASRH/HIV services into the SHA benefits package, aligned with MoH budgetary allocations and provider payment flows, to ensure counties and facilities are fully prepared to sustain services once donor funding is phased out.
- Lobby for expansion of SHA benefits package to include reimbursement for ASRH/HIV services.
- Encourage eligible adolescents (above 18 years) and young people to acquire national identification cards and register in SHA in anticipation of coverage of SRH/HIV services.

Institutionalize capacity building and mitigate staff turnover:

- Integrate adolescent-friendly SRH services training into county human resource for health systems to ensure continuity despite routine transfers.
- Digitize training using learning platforms such as Moodle to expand reach, especially given the current global health financing cuts which have made it harder to provide in-person physical training.
- Establish rapid onboarding protocols and digital training modules for new providers to minimize service gaps and reduce retraining costs.

Address operational and technology barriers:

- Connect public health facilities to internet.
- Implement alternatives to voice validation.
- Ensure reliable weekend access to accommodate school-going girls.

Deepen community and adolescent/youth ownership:

- Expand peer-led and adolescent champion models to sustain demand generation and counter social stigma.
- Work with CBOs to on-board mobilizers (including young people) as community health promoters (CHPs) within the government system.
- Incorporate young peer providers into the primary care networks (PCNs) models.

Develop a realistic and phased exit strategy:

- Define a clear roadmap for transition of financial and operational responsibility from the Joint Program partners to counties and the SHA.
- Pilot phased handovers in selected counties to test mechanisms for government ownership before scaling down nationally.
- Document and disseminate lessons from the program to guide scalability and replication across diverse contexts.

Prepare for subsequent phases with adaptive design:

- Incorporate lessons learned such as inclusion of more beneficiaries, expansion of service package, technology challenges, fraud risks, and staff turnover, into restructured subsequent phases.
- Ensure that subsequent phases emphasize sustainability mechanisms from inception, reducing reliance on external financing over time.

Consider scaling to Arid and Semi-Arid Lands (ASAL) counties during subsequent phases:

- Integrate at least two ASAL counties into the next phase of the ASRH-DIB as a pilot, with tailored implementation models for fragile settings.
- Develop and deploy offline-first or low-bandwidth versions of the Tiko platform, ensuring data can sync when connectivity is restored.
- Strengthen partnerships with CBOs, community health promoters, and county health systems in ASAL areas to ensure demand generation and last-mile service delivery.
- Add equity-sensitive indicators into the results framework to monitor uptake and outcomes specifically among adolescents in ASAL regions.

Position the ASRH-DIB within the Gates Foundation's USD 2.5B 10-Year Investment in Women's Health

In August 2025, the Gates Foundation announced a $2.5 billion, 10-year commitment to advance women's health, focusing on innovations in contraceptive technologies, STI prevention and treatment, maternal health, and menstrual health. With the Foundation's new regional office in Nairobi, there is a strategic opportunity to link innovative financing models like the ASRH-DIB with this historic investment.

Why the ASRH-DIB is a strong fit:

- Thematic alignment**:** The DIB advances adolescent SRH by increasing access to contraceptives, HIV testing and prevention, and adolescent-friendly health services, thus directly aligning with Gates Foundation's priorities.
- Innovation in financing**:** It is the first health-focused DIB in Kenya, and first ASRH-DIB globally blending philanthropic, private, and public funding to deliver measurable health outcomes.
- Scalable digital health model: The Tiko platform integrates real-time data, digital incentives, and feedback loops, making it a replicable and scalable model for other women's health areas.
- Equity and impact: The program has surpassed most of its outcome targets, expanding access for adolescent girls and beyond, while mobilizing county government and private sector ownership.

Strategic opportunities with the Gates Foundation:

- Collaborative pilots: Partner on piloting new contraceptive technologies, AI-driven SRH tools, and self-care innovations through the DIB's delivery platform.
- Blended financing: Position the DIB as a proven vehicle for co-investment, combining Gates Foundation's catalytic funding with outcome funding and county contributions.
- Learning and scale: Jointly document and publish learnings to position the DIB as a global model for financing women's health, especially in fragile financing environments.
- Proximity advantage: Engage the Gates Foundation's Nairobi office for strategic dialogues, technical collaboration, and integration with regional women's health initiatives.

Proposed next steps for engagement:

- Initiate introductory engagement with Gates Foundation's Nairobi leadership to explore alignment.
- Prepare and submit a concept note showcasing the DIB as a plausible platform for piloting women's health innovations.
- Position the ASRH-DIB as a living laboratory for implementation research, with Kenya serving as a hub for piloting Gates Foundation-funded innovations such as next-generation contraceptives, HIV prevention technologies, digital self-care tools and menstrual health solutions.

Annexes

Annex 1.0: Data Collection Tools

Annex 1.1: Desk Review Checklist

Design		
Desk Review Item	**Reviewed Documents**	**Findings/Notes**
Review the alignment of the ASRH DIB with relevant SDG targets	ASRH DIB Project Document. SDG Partnership Framework. Results Framework and Theory of Change. UN Sustainable Development Cooperation Framework (UNSDCF). Logical Framework Matrix. Implementation Plan / Gantt Chart. County Development Plans HIV and SRH policy documents	
Assess documentation on the financial instruments and their relevance		
Verify inclusion of gender, youth, and LNOB principles in the program design		
Check for alignment with national development plans and UN Cooperation Framework		
Review the logical framework for SMART indicators and targets		
Assess whether the implementation timeline is realistic and adequate		

Progress/Results		
Desk Review Item	**Reviewed Documents**	**Findings/Notes**
Compare reported results against the results framework and outcome indicators	Quarterly/Annual Progress/Impact Reports. Monitoring and Evaluation Reports. Financial Leverage Monitoring Table. Outcome Indicator Tracking Sheet. Reports on Additional Financing / Co-financing. Documentation of Innovations or Best Practices	
Review progress updates using a traffic light system (if available)		
Analyze documentation on co-financing and leveraged funds		
Assess financial leverage monitoring tools and evidence (e.g., commitment letters)		
Review evidence of systemic or catalytic impact in program documentation		
Check for learning agenda insights or documented best practices		

Management Efficiency		
Desk Review Item	**Reviewed Documents**	**Findings/Notes**
Review the project document for defined management and governance arrangements	ASRH DIB Governance and Management Structures. Meeting Minutes (Steering Committee, Technical Team); UN Joint Program Coordination Reports; Partner Agreements or MoUs. Joint Communication and Reporting Templates. Communications materials, reports from public events, UNRCO Oversight and Coordination Notes	
Assess the clarity of roles and responsibilities in reporting lines and leadership role of the RC		
Review the UN Joint Team's execution records and coordination with TIKO		
Evaluate the UNRCO's oversight role in documented correspondence		
Check the quality, timeliness, and completeness of reporting deliverables		
Review communication products for alignment with joint program branding		

Risk Management		
Desk Review Item	**Reviewed Documents**	**Findings/Notes**
Review risks outlined in the Project Document and Annual Reports	Project Risk Log or Risk Register. Annual Risk Assessments; Socio-political and Economic Risk Analyses; Field Visit Reports Highlighting Risks. UN Country Team Briefing Notes	
Assess whether risk ratings are current and appropriate		
Identify any documentation on unanticipated effects (positive/negative)		
Check for updates on political, social, or economic risks impacting delivery		

Sustainability		
Desk Review Item	**Reviewed Documents**	**Findings/Notes**
Assess documentation on sustainability of financial instruments post-DIB	Exit Strategy or Transition Plan. Sustainability Framework or Roadmap. Documentation of Public-Private Partnerships; Commitment Letters from Counties or Partners. Scale-Up or Replication Strategy. Budget Integration or Financing Continuity Plans	
Review exit strategies or phase-out plans outlined in project materials		
Check evidence of public/private sector buy-in at county and national level		
Review documentation of partnerships to support continuity and scale-up		
Evaluate the potential for replication or scale based on reported results		

Annex 1.2: KII Guide for UN Implementing Agencies (UNFPA, WHO, UNAIDS, SDGPP)

Design	
Review Question	**Responses/Notes**
How does the ASRH DIB align with the SDGs and your agency's mandate?	
How effective are the financial instruments used in this program?	
To what extent were gender, youth, and LNOB principles integrated in the program design?	

Progress/Results	
Review Question	**Responses/Notes**
What progress has been achieved in your agency's workplan under the DIB?	
Has the program leveraged additional resources or co-financing from your agency or partners?	
What barriers have limited implementation progress so far?	

Management Efficiency	
Review Question	**Responses/Notes**
How effective are the coordination mechanisms within the UN Joint Team?	
Are decision-making structures clear and timely?	
How would you assess the leadership and coordinator capacity of the UNRCO and implementing partners?	

Risk Management	
Review Question	**Responses/Notes**
What are the most significant risks you have observed in this program?	
How well has the team adapted to unforeseen challenges?	
Are current risk mitigation strategies effective?	

Sustainability	
Review Question	**Responses/Notes**
Do you believe the financial model used in this DIB is scalable and /or replicable?	
What factors are critical for sustaining results after the DIB ends?	
Are there partnerships in place or new partnerships envisaged to ensure the program continues post-DIB?	

Annex 1.3: KII Guide for Donors and Financiers (SDG Fund, CIFF, BRIDGES)

Design	
Review Question	**Responses/Notes**
What informed your decision to invest in the ASRH DIB?	
How relevant is the ASRH DIB design to broader SDG and health financing goals?	
Were you satisfied with the program's gender and equity considerations?	

Progress/Results	
Review Question	**Responses/Notes**
Has the program met its financing and performance milestones to date?	
What level of financial leverage has the program achieved?	
Has the investment demonstrated early signals of systemic or catalytic impact?	

Management Efficiency	
Review Question	**Responses/Notes**
Are reporting lines and governance structures working effectively?	
How effective are the coordination mechanisms within the UN Joint Team?	
How do you assess the transparency and responsiveness of the UN Joint Team? Tiko?	
Is decision-making timely and evidence-informed?	

Risk Management	
Review Question	**Responses/Notes**
What risks were identified at the outset and how have they evolved?	
What safeguards are in place to protect your investment?	
Have there been any surprises—positive or negative?	

Sustainability	
Review Question	**Responses/Notes**
Do you believe this model could be replicated or scaled?	
What support would be needed to institutionalize this financing approach?	
What would motivate continued investment beyond this pilot?	

Annex 1.4: KII Guide for National and County Government Officials

Design	
Review Question	**Responses/Notes**
How does the ASRH DIB align with your national and county development priorities and plans?	
Were your inputs considered during program design?	
To what extent does the results framework reflect gender and youth priorities?	

Progress/Results	
Review Question	**Responses/Notes**
What changes have you observed in ASRH/HIV services for adolescents?	
Has the program improved resource mobilization or accountability at county level?	
Are you satisfied with the pace of implementation?	

Management Efficiency	
Review Question	**Responses/Notes**
How effective is the collaboration with UN agencies and TIKO?	
How effective are the coordination mechanisms within the UN Joint Team?	
Are reporting and decision-making processes clear?	
Do you participate in any ASRH DIB coordination or governance structures?	

Risk Management	
Review Question	**Responses/Notes**
What contextual risks have affected program delivery?	
What contingency plans have worked best?	
How are county-specific risks addressed?	

Sustainability	
Review Question	**Responses/Notes**
What will it take to sustain ASRH DIB interventions post-project?	
What are your current financial contributions to the ASRH-DIB Program? (same as or different from the MoU)?	
Are you planning to integrate any part of the cost into routine health budgets or SHA packages?	
What is the estimated cost per adolescent for you to sustain these services post-project?	
Are counties prepared to absorb or replicate the model?	
What partnerships are needed to institutionalize gains?	

Annex 1.5: KII Guide for Implementing Partner (TIKO)

Design	
Review Question	**Responses/Notes**
How were you involved in designing the ASRH DIB?	
How effective are the financial mechanisms for implementation?	
Was the timeline realistic for your activities?	

Progress/Results	
Review Question	**Responses/Notes**
What results have you achieved so far under the DIB?	
What data do you report and how is it used?	
What facilitators/enablers have led to the success of the program?	
What barriers are affecting implementation success?	

Management Efficiency	
Review Question	**Responses/Notes**
How is the collaboration with the UN and government partners?	
Are the reporting processes efficient and supportive?	
Is there room for adaptive learning and feedback loops?	

Risk Management	
Review Question	**Responses/Notes**
What risks do you face in the current delivery setup?	
How do you address delays or underperformance?	
Are the reporting expectations aligned with field realities?	

Sustainability	
Review Question	**Responses/Notes**
What are your views on the sustainability of this model?	
Are the local systems ready to absorb your work?	
What support would you need or the local system need to scale your approach?	

Annex 1.6: KII Guide for Healthcare Workers

Design	
Review Question	**Responses/Notes**
Were you involved in any way in planning or designing this initiative?	
Does the current design support adolescent-friendly service delivery?	
Are there clear guidelines on integrating ASRH DIB activities with routine care?	

Progress/Results	
Review Question	**Responses/Notes**
What has changed in your service delivery since the DIB started?	
Are more adolescents coming in for SRH/HIV services?	
What tools and resources have been most helpful to you?	
Has the program contributed to observable reductions in adolescent dependency or welfare needs (e.g., social support, food programs, age-disparate relationships)?	

Management Efficiency	
Review Question	**Responses/Notes**
How do you report data related to this program?	
Are supervision and feedback mechanisms in place?	
Do you feel supported by the project's management system?	

Risk Management	
Review Question	**Responses/Notes**
Have you encountered any challenges in engaging adolescents?	
What issues may affect continuous delivery of services?	
How have you adjusted to unexpected program constraints?	

Sustainability	
Review Question	**Responses/Notes**
What would help sustain these service changes in your facility?	
Do you see integration with regular government support?	
Would you recommend this model for scale-up? If so, what elements from the project would you recommend for scaling up?	
What long-term economic benefits do you associate with improved adolescent reproductive health (e.g., improved productivity, reduced welfare burden)?	

Annex 1.7: KII Guide for CSO/CBO Representatives

Design	
Review Question	**Responses/Notes**
Were you consulted during the program's design?	
Does the DIB address the needs of vulnerable adolescent girls in your community?	
Are community voices reflected in the design or implementation?	

Progress/Results	
Review Question	**Responses/Notes**
What has changed in community engagement on ASRH since the DIB started?	
Are adolescent girls more informed or empowered?	
What outreach or support activities have worked well?	
Have you observed any changes in school attendance or dropout rates linked to program interventions?	

Management Efficiency	
Review Question	**Responses/Notes**
How effective is coordination with UN and implementing partners?	
Do you receive feedback or updates on the project's performance?	
Are reporting burdens manageable for small CSOs/CBOs?	

Risk Management	
Review Question	**Responses/Notes**
Have there been any unintended effects (positive or negative)?	
What barriers affect adolescent participation or follow-up?	
What local risks should the program be aware of?	

Sustainability	
Review Question	**Responses/Notes**
Can your organization continue similar activities post-project?	
What community systems or partners are helping you sustain efforts?	
What additional support is needed to ensure continuity?	

Annex 1.8: FGD Guide for Adolescent Girls (15–19 years)

Design	
Review Question	**Responses/Notes**
Were you or your peers involved in any part of this program's design?	
Do you think the program considered the needs of girls like you?	
Do you think it is fair and inclusive for all adolescent girls?	

Progress/Results	
Review Question	**Responses/Notes**
What services have you received or seen through this program?	
How have these services changed your experience or that of your friends?	
Do you feel your health or wellbeing has improved?	
Has the program helped you access services that you previously could not afford? Please provide examples.	
Has access to the program's services helped you stay in school? Avoid pregnancy?	
Do you feel the services provided through the program are worth your time or the effort taken to access them?	

Management Efficiency	
Review Question	**Responses/Notes**
Are the people delivering services friendly and respectful?	
Are services available when and where you need them?	
How do you give feedback about services received?	

Risk Management	
Review Question	**Responses/Notes**
Have you ever felt unsafe or uncomfortable when accessing services?	
Are there things that stop girls from coming to the program?	
What support do you wish you had if things don't go well?	

Sustainability	
Review Question	**Responses/Notes**
Would you like these services to continue after the program ends? If yes, why?	
What would help keep the services going in your community?	
What would you say to someone deciding whether to support this program again? What should they keep in mind? What can they improve/do better?	

Annex 2.0: Review Question Matrix

Review Questions	Indicators	Data Sources	Data Collection Methods	Sampling Strategies	Analysis Approach
Design					
How does the program contribute to key SDG targets and mobilization of additional resources?	• Number of SDG targets addressed • Amount of additional resources mobilized	• Program design docs • Stakeholder interviews	• Document review • KIIs	• Purposive sampling	• Thematic + SDG alignment mapping
How effective are the financial instruments and programmatic interventions?	• Stakeholder satisfaction with instruments • Outputs delivered on time	• Financial reports • Partner feedback	• KIIs • Financial review	• Purposive sampling	• Effectiveness scoring
To what extent is there public and/or private sector ownership of the program?	• Number of partners engaged • Stakeholder ratings of ownership	• MoUs • Stakeholder interviews	• KIIs • Document analysis	• Stratified sampling	• Ownership assessment
Is the JP strategy aligned with national development priorities and the UNSDCF?	• References to national and UN plans in program strategy	• National policies • UNSDCF	• Policy mapping • Interviews	• Purposive sampling	• Policy coherence analysis
Were gender, youth, and LNOB considerations integrated into program design and the results framework?	• Presence of gender/LNOB indicators • Use of disaggregated data	• Results framework • Gender guidelines	• Checklist • Interviews	• Gender-sensitive sampling	• Equity and inclusion lens
Are the logical framework indicators SMART and realistically achievable?	• Proportion of SMART indicators • Target achievement rates	• Logical framework • M&E reports	• SMART scoring tool • KIIs	• Census of indicators • Purposive M&E sample	• SMART target analysis
Is the implementation timeframe sufficient to complete activities and achieve results?	• Percent of planned activities completed on time	• Workplans • Partner interviews	• Schedule review • Partner KIIs	• Implementation sample	• Timeliness and feasibility check
Progress/Results to date					

What key results have been achieved to date versus targets?	• Progress against key indicators and targets in results framework	• Monitoring data, baseline and midline reports	• Progress review, analysis	• Monitoring sample	• Results gap analysis
How would progress per outcome area be rated using the traffic light system?	• Rating of outcome areas using defined traffic light system	• Evaluation matrix • Program dashboard	• Dashboard rating	• Evaluator rating	• Traffic light synthesis
What barriers remain to achieving the JP's objectives and how can they be mitigated?	• List of barriers identified • Mitigation measures proposed	• FGDs • KIIs • Review notes	• KIIs • Barrier mapping	• Barrier stakeholder sample	• Barrier-mitigation mapping
Has the program met co-financing targets and mobilized additional financing?	• Amount and sources of co-financing achieved vs. planned	• Financial monitoring tables • Partner interviews	• Document review • Finance interviews	• Purposive sample of funders	• Co-financing gap analysis
Are financial leverage claims supported by documentation?	• Availability of evidence for claimed leveraged resources	• Commitment letters • Receipts • Transfer reports	• Verification review	• Verification sample	• Document triangulation
Can the progress made lead to systemic or demonstrative impact in health financing?	• Examples of system changes or replication beyond program	• Outcome mapping • Stakeholder interviews	• KIIs • Case study	• Purposive expert sample	• Theory of change analysis
Have financial instruments contributed to developmental impact in communities?	• Improved service access, use, and community development	• Community interviews • Service utilization data	• Community KIIs, monitoring data	• Community sample	• Outcome mapping
Can the solutions developed be scaled to other counties or sectors?	• Evidence of replication/scaling discussions or pilots	• Scale-up plans • Internal documents	• Document review	• Scale-up stakeholder sample	• Scalability readiness assessment
Management Efficiency					
Are the current management arrangements efficient, clear, and timely?	• Timeliness of implementation • Clarity in roles and reporting	• Organizational charts • Governance docs • Meeting minutes	• KIIs, • Checklist	• Management team sample	• Efficiency analysis

How effective is the UN Joint Team and TIKO in implementation?	• Delivery rate and quality of inputs by UN agencies and TIKO	• Progress reports • Partner feedback	• Performance review	• Implementers	• Delivery assessment
What is the quality of coordination/oversight from the UNRCO office?	• Frequency and quality of coordination by UNRCO	• Coordination logs • UNRCO memos	• Coordination evaluation	• UNRCO team	• Coordination scorecard
Risk Management					
Are project risks well identified and appropriately rated?	• Number of key risks identified and updated ratings	• Risk registers • Annual reports	• Risk review • KIIs	• Document-based	• Risk heat mapping
What socio-political or economic risks may affect sustainability?	• Identified risks in social, political, and economic context	• Context assessments • KIIs	• Contextual analysis	• Thematic risk sample	• Political economy lens
Are there any unintended effects, positive or negative, from the project?	• Documented unintended positive or negative outcomes	• FGDs • Community feedback reports	• Community KIIs, FGDs	• Community sample	• Unintended effect classification
Sustainability/Exit Strategy					
What is the likelihood of sustaining financial instruments post-program?	• Operational status of financial mechanisms post-program	• Implementation and financial docs • KIIs	• Sustainability review	• Sustainability partners	• Sustainability likelihood matrix
Is there sufficient public/private partner buy-in for sustainability?	• Stakeholder perceptions of ownership and commitment	• Stakeholder feedback • MoUs	• KII tool	• Public-private sample	• Stakeholder buy-in analysis
Is there a realistic exit strategy to phase out assistance?	• Existence and clarity of exit strategy	• Exit strategy section of program docs	• Document review	• Program docs	• Exit readiness review
Can results be sustained through local ownership?	• Evidence of local partner continuation efforts	• Partner interviews • Reports	• KIIs, • FGDs	• Community partners	• Ownership indicators mapping
What factors influence the likelihood of sustainability and scalability?	• Scalability score and best practice documentation	• Scale-up and partnership documents	• Scalability checklist	• Best practice sampling	• Scalability assessment

Based on your experience with the current ASRH DIB, what do you see as the key opportunities and challenges for implementing a second phase, and what conditions would need to be in place for it to be feasible and impactful?	• Stakeholder perceptions of successes and challenges in Phase 1 • Identified opportunities and barriers for Phase 2 • Specific conditions suggested for Phase 2 readiness • Expressions of willingness to participate or fund Phase 2	• National and county government officials • UN agencies • Donors/financiers • Implementing partners (TIKO, providers) • Community organizations • Adolescents	• KIIs • FGDs • Desk review of Phase 1 reports and outcome data	• Purposive sampling of key institutional stakeholders • Stratified selection of counties and adolescent groups • Maximum variation to include diverse perspectives	• Thematic analysis to identify recurring enablers, barriers, and preconditions • Categorization by stakeholder type and level • Triangulation with desk review findings

Annex 3.0: ASRH-DIB Recommendations Matrix

While the ASRH-DIB is nearing its closure, stakeholders highlighted the importance of framing recommendations in actionable terms. This matrix therefore categorizes recommendations into immediate/short-term, medium-term and long-term actions. This ensures that lessons remain actionable and feed into future program design, financing, and sustainability discussions.

Design

Recommendation	Timeline	Responsible Actors
Adopt alternative means to voice identity validation.	Short-term (within 1 year)	Tiko, MoH, Counties, UNFPA
Include adolescent girls aged 10–14 years and young women aged 20–24 years.	Medium-term (1–3 years)	MoH, Counties, Tiko, CBOs
Include adolescent boys and young men.	Medium-term (1–3 years)	MoH, Counties, CBOs, Tiko
Broaden package of services to cover GBV, STIs, cervical cancer, mental health, sanitary pads.	Long-term (3–5 years)	MoH, Counties, UNFPA, WHO, CSR partners
Adjust, harmonize and standardize Tiko miles.	Short-term (within 1 year)	Tiko, UN agencies, Counties

Progress/Results

Recommendation	Timeline	Responsible Actors
Support girls testing positive for HIV to ensure linkage to care and treatment.	Short-term (within 1 year)	MoH, Counties, Tiko, Mobilizers, Providers

Management Efficiency

Recommendation	Timeline	Responsible Actors
Improve coordination by UNRCO office.	Short-term (within 1 year)	UNRCO, UN agencies, Tiko
Enhance documentation, internalization and dissemination of lessons learned.	Medium-term (1–3 years)	WHO, UN agencies, MoH, Counties
Strengthen reporting by private facilities and pharmacies.	Short-term (within 1 year)	MoH, Counties, Pharmacies, Tiko
Strengthen the communications strategy.	Short-term (within 1 year)	UNRCO, Counties, CBOs, Tiko, Adolescents

Risk Management

Recommendation	Timeline	Responsible Actors
Update the risk management plan.	Short-term (within 1 year)	Tiko, UN agencies, MoH, Counties
Strengthen fraud and corruption prevention.	Short-term (within 1 year)	Tiko, Counties, MoH
Address technology barriers proactively.	Short-term (within 1 year)	Tiko, Counties, MoH

Address legal and policy framework risks.	Medium-term (1–3 years)	MoH, Parliament, Civil society, UN agencies
Mitigate high staff turnover.	Short-term (within 1 year)	MoH, Counties, Tiko
Leverage unintended positive outcomes.	Medium-term (1–3 years)	MoH, Counties, CBOs

Sustainability and Exit Strategy

Recommendation	Timeline	Responsible Actors
Secure predictable financing through domestic systems.	Medium-term (1–3 years)	MoH, Counties, Treasury, UN agencies
Institutionalize capacity building and mitigate staff turnover.	Medium-term (1–3 years)	MoH, Counties, Tiko
Address operational and technology barriers.	Short-term (within 1 year)	MoH, Counties, Tiko
Deepen community and adolescent/youth ownership.	Medium-term (1–3 years)	MoH, Counties, CBOs, Youth groups
Develop a realistic and phased exit strategy.	Long-term (3–5 years)	MoH, Counties, UN agencies
Prepare for subsequent phases with adaptive design.	Long-term (3–5 years)	UN agencies, MoH, Counties
Consider scaling to ASAL counties.	Long-term (3–5 years)	MoH, Counties, CBOs, Tiko
Position the ASRH-DIB within the Gates Foundation's USD 2.5B Investment in Women's Health.	Short-term (within 1 year)	WHO, UN agencies, Tiko, MoH

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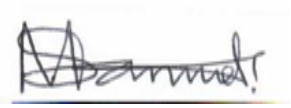
Signature:  **Date:** 30th September 2025