SHIFTING MINDS AND ACTION

CARE KENYA'S LONG RANGE STRATEGIC PLAN (LRSP) 2013-2018

Abbreviations

AOP	Annual Operating Plan
APA	Annual Performance Appraisals
ASAL	Arid and Semi-Arid Lands
AUSAID	Australian Agency for International Development
CARE	Cooperative for Assistance and Relief Everywhere
CDC	Centre for Disease Control and Prevention
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CI	CARE International
CIK	CARE International in Kenya
CLTS	Community-led Total Sanitation
CMDRR	Community Managed Disaster Risk Reduction
COMESA	Common Market for Eastern and Southern Africa
CPR	Contraceptive Prevalence Rate
CRC	Convention on the Rights of the Child
CRS	Catholic Relief Services
EAC	East African Community
ERS	Economic Recovery Strategy for Wealth and Employment Creation
ERT	Emergency response Team
FANC	Focused Antenatal Care
FGM	Female Genital Mutilation
FP	Family Planning
FPRI	Family Planning Results Initiative
FSD K	Financial Sector Deepening Kenya
GBV	Gender Based Violence
GCD	Gender and Community development
GDP	Gross Domestic Product
GF	Global Fund
GOK	Government of Kenya
GS&L	Group Savings and Loan
GWI	Global Water Initiative
HOA	Horn of Africa
ICERD	International Convention on the Elimination of all Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICCPR	International Covenant on Civil and Political Rights
ICT	Information and Communications Technology
IPIA	Individual Project/Program Implementation Agreement
IOP	Individual Operating Plan
KIHBS	Kenya Integrated Household Budget Survey
KRCS	Kenya Red Cross Society

LPCD	Litres per Capita per Day
LRSP	Long Range Strategic Plan
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rate
MNCH	Maternal, Neonatal and Child Health
MTs	Metric Tonnes
MWA	Millennium Water Alliance
MSE	Micro and Small scale Enterprises
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NCD	Non Communicable Diseases
ODA	Official Development Assistance
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PET	Participatory Education and Theatre
PMTCT	Preventing Mother to Child Transmission
POU	Point of Use
PSP	Participatory Scenario Planning
PST	Programme Strategy Team
PR	Principal Recipient
RAP	Refugee Assistance Program
RH	Reproductive Health
SACC	Sustainable Agriculture and Changing Climate
SGBV	Sexual and Gender Based Violence
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities and Threats Analysis
TB	Tuberculosis
TFR	Total Fertility Rate
TOC	Theory of Change
UCPV	Underlying Causes of Poverty and Vulnerability
UDHR	Universal Declaration of Human Rights
UNOCHA	United Nations Office of the Coordination of Humanitarian Affairs
USAID	United States Agency for International Development

Executive Summary

This strategic plan incorporates the changing economic, social and political realities of Kenya and the changes taking place within CARE International (CI) at a global level. This strategic plan outlines how CARE International in Kenya (CIK) will contribute to CI becoming a global force and a partner of choice within a world-wide movement dedicated to ending poverty. The plan is informed by CARE International's new vision for 2020, the Government of Kenya's Vision 2030 and by CARE's presence and history in Kenya since 1968. This Long Range Strategic Plan (LRSP) provides an overarching framework for shifting to a more programmatic approach and outlines the value that CIK can make to Kenyan development by maximizing the impact of CIK's programmes and operations.

The development of this LRSP took into account the on-going programmes, historical trends, and operating environment that CIK operates within. The plan also took into account the lessons learnt by CARE in East Africa and the Great Lakes. In particular, it recognized that the shift to a programme approach is a continuous and deliberate process that requires adjusting the business model, leveraging existing capacities and making strategic choices to fit within the changing context. CIK must remain realistic and resourceful, and focus on impact and value for money.

CIK's programme focus is on **"*chronic livelihood insecure women and girls constrained by lack of access to and control over productive assets, basic services and denial of rights living in urban informal and rural settings*"**. The LRSP is expected to make a significant contribution to CIK's goal **of "*women and girls in Kenya being self-reliant, having a sustainable, high quality of life and fully realizing their rights by the year 2030"*.**

The LRSP outlines both the programmatic directions and the key strategic directions that will guide CIK's operations over the next five years. The agreed upon program directions and their constituent components include: ***livelihood (agriculture value chains, WASH and climate change); financial inclusion (access to financial services and enterprise development); health (maternal, neonatal and child health, HIV/AIDS, sexual reproductive health, sexual and gender based violence and non-communicable diseases); humanitarian assistance and emergency; and refugee assistance program***. In order to achieve lasting impact on the impact group CIK will adopt four key strategic directions that will underpin implementation of the above programs. These are: ***partnerships*, *advocacy & policy*, *knowledge management & learning and organization evolution***. In support of the program shift, CIK is expected to develop an organizational M&E system that will support impact measurement and coordinate monitoring and evaluation initiatives.

1 Introduction

1.1 Overview of CARE International

CARE traces its roots back to 1945, when emergency assistance in the form of "CARE packages" were given to the survivors of World War II in Europe. With continued economic recovery and reconstruction in Europe, CARE shifted its focus from Europe to the developing world. In the 1950's, CARE expanded into emerging nations. In the 1960's, CARE pioneered primary health care programs. In the 1970's, CARE responded to massive famines in Africa with both emergency relief and long-term agro-forestry projects. Today, CARE is recognized as a proven leader, striving to bring about lasting and meaningful change in the world's poorest communities.

CARE International's Vision is of "a world of hope, tolerance and social justice, where poverty has been overcome and people live in dignity and security". CARE works in 84 countries tackling the underlying causes of poverty so that people can become self sufficient and overcome poverty. It is also delivering emergency aid to survivors of natural disasters and war, and once the immediate crisis is over, it helps people to rebuild their lives. CARE places special emphasis on working alongside poor women because, when equipped with the proper resources, they have the power to help entire families and communities escape poverty and create permanent social change.

1.1.1 CARE International Vision 2020

CARE International agreed on a vision for changing its future focus to increase its impact on poverty. In this regard, CARE International developed a strategy document (CARE International Vision 2020) that provides an overarching framework to guide its operations up to the year 2020. This strategy has two overall goals: program shift and organization reforms.

Program Shift

CARE International's shift to program approaches focuses on moving away from stand-alone project interventions in favour of longer-term strategic commitments to context specific impact populations with a clearly articulated theory of change. The shift to longer-term programs and a more networked and collective approach can lead to more sustainable impacts. CARE International agreed to adopt women's empowerment[1] – including working with men and other target populations as a principal means for achieving program outcomes while embracing gender equality.

CARE agreed to invest in and support market-based programming (*development projects achieving social impact by engaging with the poor as resilient and creative entrepreneurs and value-demanding consumers*) and social enterprises (*ventures that advance their primary social mission using business models and approaches*). It also agreed to invest in key global programs such as climate change and humanitarian assistance that would function at global, regional and country level while working in other areas responsive to local contexts.

Through program approaches, CARE will gradually and deliberately develop its resources and capacity to support, catalyze, facilitate and advocate for social change by working with and through alliances and building the capacity of local organizations to ensure a more efficient allocation and use of national resources for the vulnerable and poor communities. It also intends to leverage its global scale to connect partners and institutions within and between regions; to

[1] CARE views women's empowerment as a powerful means of reducing poverty, for all programs.

provide conduits for evidence based advocacy through knowledge management and sharing; and to develop strategic partnerships to respond to humanitarian disasters, influence disaster preparedness policies and practices, increase resilience and build local capacity to effectively respond to disasters.

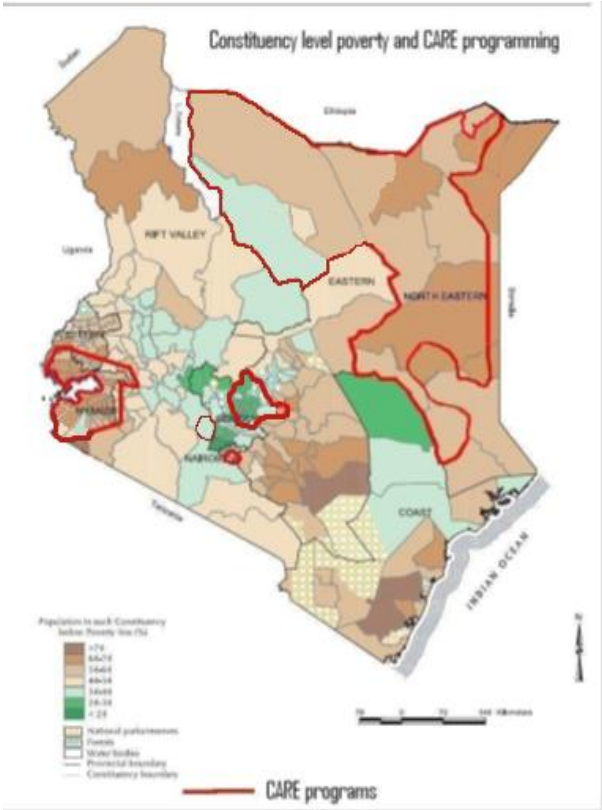
Organization Reforms

CARE International agreed on strategies to align the organization with a shift from stand-alone projects to longer-term programs. This will be achieved through an interdependent model of operating where individual lead member countries form a federation governed by a global board and secretariat, with a move towards a regional and sub-regional hub structure. Previously, each lead member country had its own operating plans, strategies and systems for managing its operations. Harmonization of critical business processes and systems was agreed upon to enhance standardization and uniformity across all CARE countries.

CARE also aims at strengthening its overall fundraising coherence and efficiency. The traditional model of fundraising through grants, established when large institutional funding was readily available had become too cumbersome and expensive. This necessitated review of the operating models in favour of more cost-effective models and was accompanied by new fundraising models which include private sector engagement and sourcing for flexible funds to support the program shift.

1.2 CARE International in Kenya

CARE International started operating in Kenya in 1968. From the onset, CARE's involvement in Kenya focused on emergency assistance, capacity and resilience building. Long-term agro-forestry projects were initiated, integrating environmentally-sound tree and land management practices with farming to provide diversification of agriculture. As early as the 1970's CARE was building synergies with local communities through initiatives such as the 'Harambee' movement – a self help movement that rallied communities' finances and human resources for common good. CARE has always valued the participation and input of communities in the planning and implementation of programmes. This human-centred design has ensured that CARE remains strong and legitimate where it works.



In 1982, CARE began focusing on empowering women through income and livelihood generating programmes[2]. CARE started the first HIV/Aids education programmes in Kenya, in 1988 when the subject was still either largely unknown or a taboo. It launched a children's magazine in 1989 to discuss HIV/Aids prevention. This was further strengthened by the *Pied Crow Education* project in 1994 as a

[2] CARE Canada Annual Reports 1982-1984.

nation-wide children's education programme. Since 1992, CARE has worked with refugees displaced by famine and insecurity in the main refugee camps in Dadaab. CARE has been the lead humanitarian agency responsible for providing life saving assistance, food, water, sanitation and hygiene facilities, counselling centres for gender-based violence survivors and support in other sectors including education.

In the past five years, CARE primarily focused on five sectors: livelihoods including resilience building, adaptation to climate change, WASH and value chain projects; health and HIV/Aids; financial inclusion, including group savings and loans; refugee assistance; and emergency response. As our programming has grown and the development landscape changed, CARE has come to the conclusion that short term, output oriented projects that fight the symptoms of poverty do not lead to structural and institutional changes required for the most poor and marginalized to rise above poverty. The organization has been working to strengthen its impact on these structural causes by shifting from stand-alone projects to a longer term programme[3] approach.

CARE has worked mostly in three geographical areas in Kenya: northern Kenya including Dadaab, Nyanza and Kibera in Nairobi. Within the current administrative boundaries, CARE works directly in 16 counties: Marsabit, Wajir, Garissa, Mandera, HomaBay, Siaya, Kisumu, Kisii, Nyamira, Migori, Vihiga, Kirinyaga, Nyandarua, Embu, Nyeri and Nairobi. The areas of coverage were informed by the Government of Kenya's analysis of poverty[4], the extent of coverage by other international NGOs, and the deliberate choice to focus on areas with highest poverty and in places where partner agencies were not already present in scale. Through the Global Fund supported HIV project, CARE works in other parts of the country, but purely through partnerships with national and a few international NGOs.

CARE Kenya's mission is to reduce poverty at the household level and to provide emergency relief. It does this by addressing the underlying causes of poverty, building capacity for self reliance, working in partnership with all stakeholders at community and national levels, programming based on sound analysis, innovation, research and learning and by addressing all forms of injustice at all levels.

2 Reflections on the 2009-2011 Strategic Plan

2.1 Overview of the previous Strategic Plan

CARE Kenya's Health sector has a diverse range of experience in health-related programming over the years. Working with communities from the very beginning, and enhancing the capacity of community health workers and health systems, CARE ensured improved health practices at community level as well as strengthened health systems. Key areas of intervention during the 2009 – 2011 period included comprehensive HIV prevention, care, support and treatment, Sexual and Reproductive Health (SRH) including family planning (FP), improving Maternal, Neonatal and Child Health outcomes and support to Orphans and Vulnerable Children (OVCs). CARE collaborated closely with communities, the Government of Kenya, community based organizations, civil society, donor community as well as other stakeholders.

[3] CARE defines a programme as "a coherent set of initiatives by CARE and its allies that involves a long-term commitment to specific marginalized and vulnerable groups to achieve lasting impact at broad scale on underlying causes of poverty and social injustice". This goes beyond the scope of projects to achieve positive changes in human conditions, in social positions and in the enabling environment.

[4] Geographic Dimensions of Well Being in Kenya Volume II

The livelihood sector sought to empower vulnerable rural communities and enhance their livelihoods through various multi-pronged approaches including food security and economic development, integrated water, sanitation and hygiene (WASH); disaster risk reduction (DRR), community based climate change adaptation and agricultural value chains making the markets work for the poor. The sector also focused on livelihood protection measures including social protection for the chronically food insecure and the most marginalized members of the community to address chronic poverty and extreme hunger. This sector implemented interventions that addressed diverse livelihood needs of different segments of the target populations. The needs ranged from inadequate water, hygiene and sanitation services, food insecurity and low income. In rural, remote and semi arid regions where living conditions are deplorable and unfavourable, CARE Kenya strived to address the causes of poverty by actively involving the local communities and stakeholders to find sustainable solutions to their own problems and needs. Relevant interventions were rolled out to mitigate effects of drought, hunger, climate change and environmental degradation as well as enhancing disaster risk reduction. The livelihoods sector hosted diverse range of projects/programs spread in different regions in Kenya including Mandera Central and Mandera East in Mandera County; Moyale in Marsabit County; Wajir North Habaswein Wajir South and Wajir East in Wajir County; Fafi, Garissa, Balambala and Lagdera in Garissa County; Siaya, Homabay, Kisumu, Kericho and Nakuru counties.

CARE Kenya's approach to financial inclusion is unique and ensures that every level in the financial value chain is addressed. This starts with capacity building savings mobilization, group formation; this creates demand for other financial services and is followed closely with micro enterprise development, bank linkage, and a pilot index based livestock insurance targeting pastoralists. Apart from investing in agriculture and livestock based enterprises, group savings and loans (GS&L) members are becoming key players in sales of solar lamps and improved cook stoves. CARE Kenya entered into strategic partnership with donors, public and corporate bodies to ensure there is continuous support for expansion of GS&L in the country and that there is effective and efficient service delivery to those at the bottom of the pyramid. CARE Kenya created demand and partnered with banks to development of appropriate savings products for GS&L groups.

CARE is a major force in humanitarian and emergency response and has a responsibility as a leader in the sector to demonstrate the highest standards of effectiveness and quality. The increasing number and impact of natural disasters due to climate change, heightened vulnerability of disaster-prone areas and Kenya's complex political situation continued to impact on vulnerable groups. Increased tensions arising from prolonged chronic poverty, unavailability and limited access to natural resources and increased inequality, poor governance and ineffective institutions contributing to inter tribal conflicts that were inextricably linked with humanitarian crisis necessitated the formation of the humanitarian assistance and emergency sector in CARE Kenya. The sector fulfils CARE's core mandate of responding to humanitarian emergencies as an essential part of fighting poverty and social injustices. The primary objective of humanitarian response is to meet the immediate needs of affected populations in the poorest communities in the world. Recognizing that people have the fundamental right to live with dignity, CARE also strives to address the underlying causes of people's vulnerability. The sector was separated from the refugee assistance programme during the 2007-2008 post election violence that rocked the country. It became a fully fledged sector during the Horn of Africa (HoA) food crisis response in 2011 with over seven projects. The sector covered all other humanitarian response initiatives apart from refugee-specific initiatives and specifically worked in Western, North Eastern, Upper Eastern provinces and Kibera slums in Nairobi.

The Refugee Assistance Program (RAP), until 2009 known as the Emergency and Refugee Operations, provided services to the refugees in the Dadaab refugee camps. The camps grew from 3 (Hagadera, Ifo and Dagahaley) in 2009 with a population of 289,315[5] to 5 by 2012 with the highest number of people reaching 474,098[6] in the month August 2012 (the new camps are Ifo 2 and Kambioos). However, the current camps population is 409,412 (June 30, 2013) following the ongoing population verification exercise undertaken by UNHCR. The program provided food and non-food items to the refugees as well as interventions aimed at improving access to quality of education, safe water, proper hygiene and sanitation.

2.2 Key Achievements

Successful implementation of these projects contributed significantly to continuing good donor relations and being awarded subsequent projects. Due to the project-focused nature of previous programming, the achievements highlighted below do not give an overall or consolidated view of achievements within the 2009-2012 periods; instead we seek to demonstrate some of the contributions of CARE's work with the community.

2.2.1 Health

With Support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, and working with 54 sub recipients, the Government of Kenya - including NACC and NASCOP - and the Kenya Country Coordinating Mechanisms, CARE Kenya, as the Principal Recipient (PR) for the civil society component of the 5 year Global Fund Round 7 HIV program contributed to improved quality of life for people living with HIV in Kenya and to reduction of new HIV infections. To achieve this goal, CARE focused on (1) increasing access to HIV counselling and testing services, (2) increasing uptake of HIV prevention and treatment services, and (3) strengthening institutional capacity of local institutions and organizations to effectively implement and monitor the program. With support from PEPFAR through the US Center for Disease Control and Prevention (CDC), CARE supported the roll out of PMTCT interventions in the Western parts of Kenya including Kisii and Nyamira counties as well as supporting the implementation and expansion of high quality HIV prevention, care and treatment activities at facility and community levels. The program supported a reduction in HIV infections and improved the quality of life for individuals, families and communities, and in doing so, made a measurable contribution to the goals of the Government of Kenya and the global "3-12-12" goals of the President's Emergency Plan. Key programatic focus areas included (1) increasing; (2) increasing the quality, access and utilization of HIV care and treatment at the community and facility; and (3) strengthening the capacity of indigenous organizations and the Ministry of Health. With support from USAID, CARE contributed to the mitigation of the effects of HIV and AIDS through strengthening collective community capacity to cater for OVC needs in Kibera, Nairobi. Key programmatic focus areas included (1) strengthening the economic coping mechanisms of OVC families, (2) strengthening the capacities of local organizations to meet the needs of OVCs, and (3) reducing stigma and discrimination against OVCs and their families. CARE also supported communities in Kibera to enhance institutional capacity of local organizations that work directly with youth, as well as providing youth – especially girls – with opportunities to develop and practice leadership skills as well as promoted and protected human rights for vulnerable women, children and people living with HIV. During this period, CARE also worked with other donors to ensure enhanced HIV prevention, care, support and treatment in Kenya.

[5] Briefing Kit, UNHCR Sub Office Dadaab operations 2009
[6] UNHCR population statistics by country of origin, sex and age group August 12, 2012

In Western Kenya, CARE's Family Planning Results Initiative (FPRI) worked with communities to increase the knowledge and utilization of modern methods of family planning by transforming traditional harmful social cultural practices and promote couple communications which hinder a positive health seeking behaviour and propagate gender inequalities in the community. The program sought to strengthen locally driven advocacy that is generated through social dialogues and enhancing structured advocacy efforts among strong cultural groups who form part of custodians of culture. We implemented this through a range of different methods including social analysis facilitation, participatory educational theatres, partnering with religious leaders and community social champions. CARE remained a key stakeholder in the implementation of maternal, neonatal and child health services, prevention programs as regards sexual and gender based violence and harmful practices, community level health rights as well as having worked with government and communities to ensure health systems are strengthened both at facility and community levels.

2.2.2 Livelihood

CARE Kenya contributed by improving water delivery infrastructure at four community schemes, rainwater harvesting in schools and health facilities and this ensured that there was adequate water supply, improved storage capacities as well as safe and clean water for domestic use. About 7,100 households benefited directly from increased access to portable water supply in Saka, Balich, Balambala and Nanighi. These water infrastructures were effectively integrated with sanitation facilities development and hygiene promotion. The beneficiaries were trained on protecting and conserving their environment through tree planting, households' water quality improvement by adopting point-of-use (POU) methodology. Use of low cost materials for households' latrines and constructing of user-friendly latrines for people with disabilities in schools added significant value. Promoting hygiene messages by use of participatory education theatre (PET) approach was quite effective. The messages were specifically tailored to enhance adoption of appropriate hygiene and sanitation behaviour. An estimated 2,310 households benefited from better sanitation services.

Through Participatory Scenario Planning (PSP) approach stakeholders shared their knowledge about future seasonal climate forecasts, developed climate impact scenarios based on these forecasts and used the scenarios to make recommendations, or advisories for decision making on adaptation, livelihoods improvements, development and disaster risk reduction (DRR). This has led to increased communities' capacity to make more informed choices on their livelihood activities.

Linkages to livestock markets have been enhanced providing an outlet for livestock off-take. Coupled with sensitization to farmers and exposure tours to terminal markets as well as linkages to financial institutions, pastoralists have managed to get contacts and secured contracts and market linkages that help boost their incomes from livestock.

Under Safe Water System's school model involving CARE Kenya and CDC, final evaluation showed significant improvement in household adoption of water treatment (Water Guard and P&G purifier of water known as PUR), increase in student and parent proper hand washing techniques and decreased absenteeism rates among students. From baseline to 3-month follow-up, parental awareness of PUR increased (49–91%), awareness of Water Guard remained high (93–92%), and household use of PUR (1–7%) and Water guard (6–13%) increased, and were maintained after 13 months. Pupil absentee rates decreased after implementation by 26%.This school-based program resulted in pupil-to-parent knowledge

transfer and significant increases in household water treatment practices that were sustained over 1 year. CARE Kenya developed a curriculum and reference materials on school WASH that were approved by the Kenya Institute of Curriculum Development.

The Sustainable Agriculture for a Changing Climate (SACC) project contributed to improved productivity and sustainability of land use systems in selected watersheds in the Nyando river basins through the adoption of an integrated ecosystem management approach focusing on sustainable use of natural resources, adoption of sustainable agricultural practices and increase in land productivity

2.2.3 Group Savings and Loans

CARE Kenya contributed to enhancing financial outreach of the unbanked and promoted financial inclusion through linkage of mature savings groups to formal financial institutions through mobile technology. The group savings and loan approach empowers the community in resource mobilization and initiation of income generating activities thus creating a savings and entrepreneurial culture. CARE went into strategic partnership with Financial Sector Deepening in Kenya (FSD K) and developed community based financial service delivery channels that have resulted in over 650,000 people (78% women) accessing loans from personal savings. Through support from FSD K, CARE Australia and Barclays Bank, CARE Kenya managed to expand GS&L to some of the remotest parts of the country like Marsabit, Mandera, Garissa and Mageta Island in Lake Victoria.

To address the challenge of long distances to banks facilities, CARE Kenya strategically worked with banks already in partnership with network service operators to develop special SIM cards for savings groups and the first multiple PIN SIM card in the CARE-Equity-Orange partnership was launched in March 2012 when for the first time savings groups transacted through mobile technology. The multi-PIN SIM card has allowed savings groups to maintain security whilst banking through mobile phone services. This partnership has also resulted in a number of research studies done in Kenya and thus helping in improving savings group quality and development of new products for the market. CARE in partnership with FSD K and CRS is currently piloting savings group e-recording in Kenya.

2.2.4 Humanitarian Assistance and Emergency

CARE Kenya established strategic alliances and partnerships with local organizations in northern Kenya, areas perceived to have limited humanitarian access due to insecurity. During the HOA drought response, the worst drought in sixty years, the sector developed flexible program strategies that addressed both the underlying drivers of poverty and vulnerability and the impacts of increasingly frequent shocks such as natural disasters and conflicts by strengthening community resilience and disaster risk reduction and preparedness. Over the same period of drought response, 815,452 (163,090 households) direct beneficiaries were reached and another 1,300,069 community members benefitted indirectly. The method of delivery of these projects include capacity building of community institutions for resource management, both conditional and unconditional cash transfers to strengthen asset base, improvement of sanitation facilities and rehabilitation of water facilities, mass vaccination and treatment of livestock to increase access to quality animal health services, strengthening livestock diseases surveillance mechanisms using existing local institutions. Additionally 5,000 households benefited from life saving activities in western Kenya during the flash floods of October-December 2011 short rains.

2.2.5 Refugee Assistance Program

Refugee Assistance Program (RAP) strived to improve the lives of refugees with notable achievements in its various projects. In water sanitation and hygiene, the first water reticulation map in Dadaab camps (Dagahaley, Ifo and Hagadera) was produced in 2010. The program also re-designed the water reticulation system in the initial 3 camps of Dadaab with the introduction of elevated steel tanks to enhance water delivery at the recommended pressure. In addition, the program ensured an increase in water supply yielding average water per capita of 18-19 lpcd from 10 lpcd through replacement of the old lower yielding boreholes with high yielding ones. Distance to water points has also improved from 500m-600m to 200m-250m, reducing the amount of time refugees spend to fetch water.

In Gender and Community Development (GCD), RAP increased awareness and reporting on GBV cases through innovative community voluntary involvement initiatives such as neighbourhood forums, "We can campaign", safe homes and men action groups. The implementation of GBV information management system has enhanced GBV data collection and analysis informing GBV programming strategies. The program has worked on skills transfer to refugees in ICT, small scale business management, multi storey gardening, garment production using handloom, tailoring, food processing for business and scholarships thus empowering refugees both socially and economically.

Through the education sector, RAP operates 6 primary schools in Dagahaley refugee camp with a classroom pupil ratio of 1:75, which is an improvement from 1:91 in 2009. A notable achievement was the implementation of two schools in one concept (morning and afternoon schools operated in the same facilities) in one of the schools. The sector has also established 5 early childhood education sectors so as to give children age appropriate learning centres as opposed to sharing facilities with older learners.

In food security and logistics, RAP increased its capacity in handling food tonnage. In 2009, 62,793 MTs of food was distributed to 284,546 refugees. The tonnage handled increased over the years and in 2012 we distributed 86,154 MTs to 463,608 refugees. The mechanical services unit has also increased its capacity to handle 308 vehicles and equipment compared to 85 in 2009.

2.3 Key Challenges

There has been heightened insecurity in the north east region during the period. The organization adopted stringent travel measures to cope with the changing security situation, to ensure the safety of the staff. This included obtaining security clearance to the program areas resulting in restricted movement of staff. Some areas were not accessible during some periods. CARE still maintains a 100km security cordon from the Somali border. Access to this area is only through advance approval of the Safety and Security Deputy Director or Country Director.

Recurrent droughts in north east region adversely affected people's livelihood thereby compromising local coping mechanisms. Community participation in most of the projects was therefore hindered thereby perpetuating dependency on external support.

Upon completion of a project and graduation of savings groups, there has been very little follow-up of already established groups due to funding constraints. Adoption of the group savings and loans methodology by partners and other organisations has metamorphosed and in some cases undermined the core principles of GS&L that advocate for local resource mobilization by providing seed capital to the groups.

Coordination of humanitarian response especially at the height of HOA drought response proved challenging as new organizations made entry into new places where they had no prior experience. Competition among humanitarian actors increased as the mode of delivery of life saving services differed from one organization to the other due to donor pressure and fear of returning the funds. This was overcome by the formation of humanitarian hubs in eight regions by UNOCHA. Fund raising for small scale and rapid emergencies was challenging as it did not attract donor funds although lives were threatened. KRCS and Government had prepositioned emergency stocks and they were the first to respond to emergency situations.

2.4 Lessons Learnt

Involvement/engagement of communities from inception of projects is vital to successful implementation of health projects, since these build on existing community capacities; and partnerships with local organizations, Government and other stakeholders are effective and key in successful programming.

There is need to concentrate on creating demand for sanitation through community led total sanitation (CLTS) in future as opposed to direct support to households on latrine construction. This will encourage all the targeted beneficiaries to strive through their own efforts to have latrines.

When regular consultations and collaboration are done with key partners and beneficiaries, the implementation process becomes smooth and participatory. Key stakeholders become very supportive of the project, thus making it achieve its planned objectives.

Building on previous and ongoing program/project work through the leveraging of additional resources contributes to continuation and completion of the activities initiated hence enabling to consolidate impact and outreach to more beneficiaries as was the case in GWI/AusAID/MWA running dry programme.

CMDRR approach has worked well towards self-reliance with cross-border pastoralist communities in terms of cross-border natural resource sharing and management. There is increased awareness of risk by communities which can trigger community led risk reduction actions which is cost effective and sustainable in the long run.

The 2009-2011 Strategic Plan had a broad focus and was all-encompassing with regard to the challenges it envisioned to address and the impact groups that had been targeted. This arose from the previous programming model within CARE that targeted to work with the entire community. The shift to embracing program approaches was taking shape during the life of the plan and in particular the strategy for addressing the underlying causes of poverty of specific impact groups. In view of the changing development landscape and the experience in programming over the decades, CARE realized that it needed to change its programming model in favour of longer-term programs with a more specialized focus on women's empowerment and in areas where it could leverage its existing capacities.

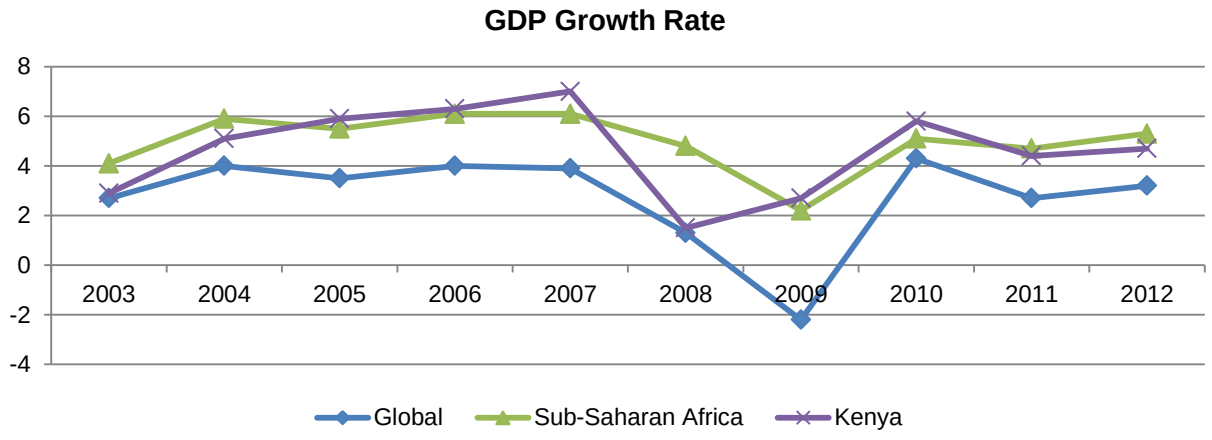
The monitoring and evaluation system was weak and needed strengthening to ensure that there was increased accountability for impact at all levels. Monitoring, evaluation and reporting was based on donor requirements on a per project basis. The individual project implementation agreement (IPIA) stipulated the information requirements for the project, with a reporting template provided according to each donor's information requirements and did not elicit

information beyond immediate project results. Accountability was donor focused, while monitoring and evaluation collected information on outputs and activities. There was no standardized method used to collect data and no mechanisms existed to link individual project achievements to the organizations strategic plan or to demonstrate organization-wide progress. Project evaluations were primarily conducted when required by the donor, with limited resources set aside for organization-driven evaluation and impact measurement. Other initiatives to collect information were done in an ad hoc manner using tools such as human interest stories, case studies and success stories. Weaknesses in the monitoring and evaluation systems contributed to continuous loss of institutional memory and failure to document community driven innovations that would have contributed to income generation through patents of products such as Water-Guard, pied crow magazines and Veg-Pro products.

3 Operating Environment

3.1 Socio-Economic Environment

The global economy had been growing at a steady rate until 2008 when it began to deteriorate following the global financial crisis and the resultant uneven recovery[7]. Developed countries have been faced with various economic distresses such as slowed output growth, high unemployment, weak aggregate demand, high public debt burdens and financial sector fragility. Economic growth in the major developing countries and economies in transition has decelerated notably, reflecting both external vulnerabilities and domestic challenges[8]. Most low income countries now face intensified adverse spill over effects from the slowdown in both developed and major middle-income countries. For many developing countries, the global slowdown implies a much slower pace of poverty reduction and narrowing fiscal space for investments in education, health, basic sanitation and other critical areas needed to accelerate the progress to achieve the Millennium Development Goals. This is critical for less developed countries since they remain highly vulnerable to commodity price shocks and are receiving less external financing as official development assistance (ODA) declines in the face of greater fiscal austerity in donor countries.



Sources: World Bank, IMF, African Development Bank, Kenya National Bureau of Statistics

[7] World Economic Outlook 2012
[8] World Economic Situation and Prospect 2012-2013

In the last decade, Kenya's economic performance has been increasing steadily as illustrated above. In 2008, the country experienced a sharp decline in growth mainly due to post election violence and high food prices. The political crisis disrupted agricultural production while inadequate rainfall and tripling of input prices especially fertilizer made the situation worse. Like many countries in the world, Kenya was affected by the 2008 global food crisis[9]. Food prices increased sharply alongside international food prices which had a negative impact on most of the poor in urban and rural areas. There was mild recovery in economic growth in 2009 when compared to the 1.5% growth in 2008, even though this remained below population growth rate. Rapid economic growth was hampered mainly by the global financial crisis and the occurrence of the worst drought in the decade.

In 2011, the protracted drought in the Horn of Africa led to a massive influx of refugees and significant loss of livestock[10]. Food shortages contributed to increasing food prices and substantial food imports. Food inflation contributed significantly to increased overall inflation. Low water levels, led to a decline in hydropower generation and a shift towards emergency diesel generated power. As a result of the Middle East crisis, global fuel prices increased resulting in a 42.2% increase in Kenya's oil import bill. The increase in global oil prices triggered an increase in diesel prices which in turn increased the cost of diesel generated power, and resulting in increasing costs of production for both the manufacturing and service industries[11]. The Euro crisis created uncertainty in the global markets and increased currency volatility. The weakening of the Kenyan shilling was attributed to this crisis. The combined effect of multiple macroeconomic shocks contributed to increased inflation that reached 20%. Consequently, high inflation tends to disproportionately affect the poor by eroding their purchasing power.

Demographic Transition

Kenya has an area of 58 million hectares[12], with about 11.6 million hectares of the land is classified, on the basis of rainfall, as medium to high potential with the rest is mainly arid and semi-arid lands (ASAL). According to the 2009 Kenya population and housing census, Kenya's population is approximately 40 million. The population growth rate of 3%[13] threatens the country's capacity to meet the basic needs of its current population. At this rate of growth the projected population by 2030 will be about 65 million. Kenya's population will continue to rise rapidly due to high fertility in previous decades that resulted in the formation of many more families, thereby implying that the total number of children continues to grow and as a result of increased life expectancy from 54 years to 68 years[14].

The KIHBS[15] suggested that in 2005/2006, 47% of the population lived in poverty. Kenya is predominantly rural with about 80% of the population living in rural areas. Agriculture is a major contributor to growth and employment. The incidence of poverty is lower in urban areas compared to the rural areas. According to the 2009 Kenya Population and Housing Census, 30% of the population lives in urban areas which included cities, municipalities, towns and other urban areas. These areas are characterized by higher population density and higher standards of living. The country is experiencing rapid urbanization owing to increased rural-urban migration with approximately 250,000 Kenyans moving to cities every year and as formerly rural

[9] Kenya Economic Update, Dec 2009
[10] Kenya Economic Update, Dec 2011
[11] Kenya Economic Update, Dec 2012
[12] Kenya Poverty and Inequality Assessment Report 2009
[13] http://www.planning.go.ke/index.php?option=com_content&view=article&id=329:kenya-to-address-rising-population-growth&catid=1:latest-news&Itemid=53
[14] Kenya Economic Update, Jun 2011
[15] Kenya Integrated Household Budget Survey

areas become increasingly urban. In the last two decades, Kenya's urbanization level was 18 per cent[16]. With proper management, urbanization presents an opportunity for rapid economic growth by increasing productivity and benefitting from agglomeration[17] effects. However with continued poor planning, the negative effects may surpass the benefits through increased slums, higher crime, congestion and strained infrastructure and basic amenities. As a result of urbanization, Nairobi has become an industrial hub for the regional COMESA/EAC markets and is an emerging location for global services.

3.2 Political Environment

Reforms in Kenya began in 2003 following poor economic performance in the previous two decades. The 2003 economic recovery strategy for wealth creation and employment (ERS) laid a foundation for economic and structural reforms that resulted in rapid economic growth between 2003 and 2007. Major reforms however, began in 2008 with the development of Kenya Vision 2030 that was launched in June 2008 outlining the country's strategy to transform into a newly industrializing, middle-income country providing high quality of life for its citizens in a clean and secure environment[18]. The Vision 2030 provided the underlying framework for economic, social and political reforms.

In 2007-2008, the post election violence in Kenya resulted in more than 1350 deaths and the displacement of over 600,000 civilians. Peace talks between the warring political factions led to the formation of the grand coalition government and the creation of three commissions to oversee implementation of key mediation processes and provide framework for peace in subsequent elections. Kenyans participated in peaceful elections in March 2013 amidst fears of post election violence. This preceded a Supreme Court petition disputing electoral results, with the court upholding the electoral results as announced by the Independent Electoral and Boundaries Commission (IEBC). This led to a peaceful transfer of power in accordance with the constitutional provisions.

The 2010 Constitution of Kenya became law and introduced major political reforms. The key changes proposed by this constitution provided for the separation of powers between the three arms of government (executive, legislature and judiciary), introduction of a new upper house in parliament (senate), devolution of power with only two levels of government (national and county) and key issue on citizenship (gender inclusion and dual citizenship). The new constitution attempts to resolve the issues of state power and citizens rights and control over the development process. It provides a framework for democratic reforms, devolution of state power, land reforms, gender equality and human rights.

Kenya's devolution created new political and administrative units by replacing 8 provinces, 175 local authorities and 280 districts with 47 new counties. Each county is required to have an elected assembly, a governor and an executive committee of which the latter two are from outside the assembly to ensure separation between the legislature and the executive at county level. The national government is mainly responsible for policy and oversight and retains some important service delivery functions such as education and social welfare services as well as expected national prerogatives such as defence and foreign affairs. County governments are responsible for a range of service delivery functions (health, agriculture, transport, water) previously performed by the staff of many de-concentrated line ministries, urban functions

[16] Kenya Economic Update June 2011
[17] Agglomeration benefits are derived when people and firms locate in proximity to each other thereby generating large enough markets for products, sufficient labour to work in factories, and new space for innovation.
[18] Kenya Vision 2030

performed by the local authorities and some of the functions of the provincial and district administrations (liquor licensing and control of drugs). Each county government will have its own public service and appoint its own public servants within a framework of uniform national standards. A minimum of 15% of the national revenue is required to be transferred unconditionally to the counties with other allocations made through the budgeting process. Counties are also expected to generate their own revenues though collection of property and entertainment taxes, business licensing fees and charges from other services.

The long-standing conflict in Somalia originated from inter-clan clashes and rivalry of power, warlords trying to assert their control over various regions in the country and border conflicts with neighbouring states, particularly Ethiopia and Kenya[19]. As a result of this conflict, thousands of lives were lost, property was destroyed and people were forced to flee their homes and seek refuge in other countries, while others were internally displaced. In 2012, approximately one million Somali refugees were hosted in neighbouring countries with 500,000 of these hosted in the Dadaab refugee camps in north eastern region of Kenya. This large presence of refugees poses a great social and economic crisis for Kenya, while at the same time it presents economic opportunities for business within the country. In recent years, increasing security concerns brought about by the reported infiltration of al-Shabaab militia has increased opposition to the presence of the refugee camps and political calls for refugees to return to Somalia. Cross border kidnappings and arms smuggling, reports of extremist recruiting within refugee camps and Kenyan cities, increased allegations of terrorist plotting, and public threats by al-Shabaab leaders led to heightened recognition among government officials, the diplomatic community and civil society that Kenya remained vulnerable to terrorist attacks. In October 2011, Kenya launched a military intervention in Somalia "to protect its territorial integrity from foreign aggression". Since the launch of the 'operation linda nchi'[20], Kenya has experienced more than 30 attacks involving grenades or explosive devices linked to al-Shabaab[21].

3.3 Environmental Changes

Kenya's disaster profile is dominated by drought, floods, diseases and epidemics that often disrupt people's lives and are driven primarily by climatic changes and environmental degradation. Like many other countries in the world, Kenya has experienced an increase in the frequency of disasters in the last two decades[22] resulting in increased number of people affected, damaged property and economic loss.

Climate Change

Climate change poses significant threats to ecology and human life. According to the National Climate Change Strategy, as a result of global warming[23], the country has experienced increased levels of atmospheric temperature (with the days becoming much hotter while the nights and early morning temperature marginally reducing) and changes in the amount and pattern of precipitation (general decline of rainfall in the main rainfall season of March-May – 'long rains', increase in the short rains season 'October-December' which seems to extend to the dry and hot period of January-February).

[19] Kenya's military intervention in Somalia: an intricate process, ACCORD, Nov 2012
[20] Operation "linda nchi' is a codename for the military intervention by Kenyan forces in Somalia
[21] Kenya's military intervention in Somalia, Africa Report No 184, Feb 2012
[22] Draft National Policy on Disaster Management in Kenya
[23] Global warming is the increase in the Earth's surface temperature associated with the green house gases such as water vapour and carbon dioxide leading to increase in temperature.

The occurrence of drought and floods has increased in the recent past rendering more and more people vulnerable and unable to recover from their effects. The country is vulnerable to major floods and droughts, associated with El Niño and La Niña years in addition to other influential regional processes. Recent major droughts occurred in 1998-2000, 2004-2005, 2009 and 2011 and major floods occurred in 1997-98 and 2006[24]. Large parts of the coastal population are faced with flooding risks from intensification of storm surges and rising sea levels[25]. The change in climate has accelerated extinction of endangered species and ecosystems, and proliferation of invasive species, pests and pathogens. Prolonged drought has led to animal migration while creating conflict between wildlife and human beings. Forest fires are increasing as it gets hotter and drier.

Changing climatic conditions have increased the incidence and geographical spread of vector-borne, rodent-borne and water-borne diseases such as malaria, rift valley fever, dengue fever, yellow fever, encephalitis, typhoid, amoeba, cholera and bilharzias[26]. Vector borne diseases have easily spread to areas with higher altitudes and latitudes as a result of warmer temperature and variation in rainfall, leading to disproportionately higher costs of managing the diseases in the highland areas which historically have low immunity to these diseases.

Environmental Degradation

Forests act as climate regulators by controlling microclimates through the amount of shade, attracting rainfall, augmenting air movement and maintaining the humidity regimen. Deforestation[27] and forest degradation[28] occur due to increasing demand for energy (especially uncontrolled collection of firewood), human settlements, commercial logging, and livestock grazing. Deforestation and forest degradation destruct the infiltration capacity of the land, accelerate loss of topsoil, disrupt nutrient cycles and reduce biodiversity. The Mau Forest is Kenya's largest "water tower" where profound forest degradation and depletion of substantial area of forest cover continues to decrease the buffering (water storing) capacity and weakening the capacity of the land to endure long drought periods.

Land degradation[29] manifests itself through soil erosion by wind and water, soil acidification, soil salinization, change in soil structure and loss of organic matter. In arid and dry lands, land degradation (desertification) manifestation includes reduction in soil moisture retention. Land degradation contributes significantly to low agricultural productivity and food and water insecurity.

4 Programme Directions

4.1 Long Range Strategic Plan Process

The shift towards the program approach in CIK began in early 2010 and was triggered by the move towards program approaches amongst lead member countries within CARE International in 2007. The shift from stand-alone projects to longer-term programs came about after CARE's realization that shorter term projects do not achieve lasting positive impact nor address the

[24] UNDP Kenya Disaster profile
[25] Environmental Security Assessment, January 2011
[26] National Climate Change Response Strategy
[27] Deforestation involves quantitative decrease in the area covered by forest.
[28] Forest degradation involves the decrease in quality, i.e. decrease in its condition, related to different forest ecosystem components (vegetation, layer, fauna, soil)
[29] Land degradation refers to loss in productivity of land and loss of its ability to provide goods or services as a result of natural and human-induced changes in physical, chemical and biological processes.

underlying causes of poverty. In early 2010, meetings were held with staff in Nyanza and northern Kenya to develop draft regional strategies in order to come up with clear and common directions for all CIK members. These meetings revealed that most staff had not been exposed to CARE's underlying causes of poverty framework, the program approach and the theory of change. In addition, most staffs were unable to effectively apply CARE's unifying framework as a tool of analyzing the underlying causes of poverty and vulnerability and having no clear distinction between the impact groups and target groups. In September 2010, sectors embarked on modifying their projects to make them more integrated, exploit inter-project synergies and enhance linkages and collaboration among sectors as a first attempt towards moving to longer-term programs. The programme strategy team (PST) was formed in February 2011 to oversee the long range strategic plan development process. The PST identified key internal capacity gaps in gender, the unifying framework and the theory of change and proposed trainings to facilitate the shift towards program approaches.

The program approach training was held in May 2011 with the aim of facilitating a common understanding of the proposed changes, the underlying frameworks that support such a shift as well as fitting the then existing model of operation through projects to programs. This was followed by analyses on the underlying causes of poverty that were conducted in Nyanza and northern Kenya. In February 2012, CIK initiated a desk review of underlying causes of poverty at national level that provided the framework programmatic interventions. This provided the underpinning framework for development of programs. In May 2012, CIK undertook a SWOT analysis which was followed by a trend and stakeholder's analysis in June 2012. These analyses were conducted with the aim of determining the internal and external factors that were favourable and unfavourable in achieving CIK's objectives of developing longer-term programs, identifying the key stakeholders and alliances needed to complement CIK's work, and understanding the prevailing trends that would influence CARE's current and future interventions.

The initial theory of change workshop was held in August 2012 with the aim of training staff on the TOC concepts and commencing the analysis needed to formulate a theory of change based on the underlying causes of poverty analyses. The LRSP workshop held in September 2012 represented an important step in CIK's transition to program approaches and involved staff, partner agencies, key government ministries and representatives from lead member countries. The workshop served as a platform for learning across regions on the progress made towards program approaches. It provided feedback to the developed theory of change, shared an understanding of partnerships and developed consensus on the key strategic directions for CIK. In November 2012, the PST held another workshop where the domains of change and the pathways of change were further developed. This was followed by a theory of change refinement workshop in January 2013, where the PST with support from the regional office embarked on prioritization of programmatic directions using the MacMillan matrix tool. This exercise was completed with a final workshop in June 2013.

4.2 Key Milestones

4.2.1 Underlying Causes of Poverty

CIKs programming focuses on addressing the underlying causes of poverty. This is directed by the theory of change that states that interventions at this level will lead to a lasting change in the lives of women and girls. The underlying causes of poverty and vulnerability analyses (UCPV) findings revealed that the causes of poverty occur at three levels: immediate, intermediate and underlying. The **immediate causes of poverty and vulnerability** have a direct effect on

poverty and vulnerability and relate to life and survival and whose immediate effects are disease, famine, environmental disasters and conflict. At this level, these causes of poverty manifest as deprivation of basic human needs such as food, water, shelter and enhance communities' vulnerability to external shocks. Some of the immediate causes identified include:

Food insecurity

According to the UCPV it was established that approximately one third of the Kenyan population suffers chronic food insecurity and are often in need of food and non-food assistance especially during droughts and floods. Recurrent and prolonged drought occurring in more frequent cycles coupled with unpredictable weather conditions has resulted in acute food shortages. The situation is often worsened by increasing food prices, inefficient food distribution and marketing systems, reliance on rain-fed agriculture for both subsistence and livestock farming. As a result there exist regional disparities in terms of chronic malnutrition and increased vulnerability.

Recurrent drought

Kenya has in the last decade experienced increasing cycles of drought that have created pressure on existing pastures and water resources on which communities depend for their survival. Many of the crops planted at the onset of rains fail to mature when rainfall ends abruptly. This situation not only affects crops and livestock, it enhances water scarcity for domestic use and environmental degradation as communities struggle to cope. This has often led to rampant migration especially by men in search of livelihoods. Women and girls are often forced to walk for long distances in search of water and engage in petty trade including prostitution for those who live nearby towns to supplement family incomes.

Floods and diseases outbreaks

Kenya experiences seasonal floods as a result of torrential rainfall causing displacement of people living in the lowlands. This usually leads to waterborne disease outbreaks, disruption of livelihoods, migration in search of livelihoods especially by the men, loss of property and life. Rescue centres for these families are usually overcrowded with minimal facilities to support the affected people. In such dire conditions where there is limited access to food and sanitation facilities, women and children tend to suffer disproportionately compared to the men.

Limited access to improved water and sanitation

It is estimated[30] that 41% of the Kenyan population lives without access to safe drinking water, relying on unprotected wells, springs or informal water providers while 69% do not access safe and hygienic toilets or latrines. The sanitation and water crisis is especially exacerbated in urban slums and informal settlements where slum dwellers pay up to eight times more for unsafe water obtained from informal vendors. In most communities, women and girls bear the responsibility of providing water for their families and in doing so expose themselves to risks and unsafe conditions. Girls frequently drop-out of school in search of water and as a result of difficulties with sanitation within schools.

Over dependence on rain-fed agriculture and hydro power

Kenya's vulnerability to drought results from its high dependence on rainfall for economic and social development. This high reliance on rainfall especially affects the agriculture sector as it heavily relies on rainfall for production and the industrial sector that relies on hydro-power for manufacturing.

[30] WHO & UNICEF 2010

Limited access to basic services in informal settlements

Slums in Kenya are arguably among the worst in Africa, with high population densities averaging 250 dwellings per hectare. Most of these informal settlements lack formal development plans resulting in structures being erected haphazardly impeding development of basic infrastructure and facilities such as roads, pit latrines and water supply systems. Women are affected more by these poor conditions than men because of their need of greater privacy, menstrual cycles, and greater time spent within the settlement rather than going out for work.

Impact of HIV/AIDS

Even though HIV prevalence has reduced significantly in a decade, the country continues to face a mixed epidemic where both the most at risk populations and the general population contribute significantly to transmission. The most at risk population groups include commercial sex workers, same sex partners, injecting drug users, discordant couples, truckers, cross-border mobile populations and young women aged between 15 and 24. HIV prevalence in the country is higher in informal settlements, Nyanza and northern Kenyan and is primarily triggered by poverty and retrogressive cultural practices. Women in these three regions are increasingly becoming heads of households partly due to the disease and other existing social problems, yet they are constrained by access to land and productive assets. They also lack meaningful economic engagement which creates pressure for many to turn to prostitution or transactional sex for survival.

Sexual and Reproductive Health

The high rate of maternal mortality in Kenya is directly caused by pregnancy, childbirth, unsafe abortions and obstetric complications that result from insufficient or inaccessible antenatal care. There are regional disparities in access to antenatal care even though the level of education and income by the women contributes significantly. Access to contraceptives is significantly impaired by inadequate provision and distribution and limited resource allocation. The national teenage pregnancy rate[31] stands at about 20%. Poverty and material deprivation often pushes girls into activities that expose them to sexual exploitation and survival sex in exchange for money and food. In such situations, young girls are not in a position to negotiate safe sex and are often at risk of pregnancy and STIs including HIV/AIDs[32].

The **intermediate causes of poverty** directly relate to what people lack such as: lack of access to basic services, lack of skills, lack of productivity etc. At this level, the immediate effects manifest as inequalities between individuals, different ethnic groups, the rural and urban and between the sexes. The intermediate causes of poverty include the following:

Access to resources and employment opportunities

Approximately, 12.7 million people aged 15-64 were employed, while 5.3 million were inactive[33]. Nationally, the work force grows by 500,000 youths annually but only 25% are absorbed into jobs while the rest remain unemployed or survive on casual labour with disparities existing between the rural and urban employable population. The agricultural sector accounts for 24% of the GDP and 62% overall employment with approximately 70% of its workforce being women who provide unpaid labour. Rural populations continue to have limited access to financial services as both the banking and micro-finance sectors face operational challenges in expanding such services to these marginalised populations. Women are disproportionately affected by the lack of collateral and other productive assets that would enable them start small businesses.

[31] CSA 2008
[32] Muganda – Onyando & Martin Omondi 2008
[33] 2008 Labour force report and Kenya Integrated Household Budget Survey

Access to education

During the colonial period, women were not included in mainstream schooling programs. The home was seen as the woman's domain, with decision making and economic activities preserved for men as the household head (Shani 2006). Education for women was limited to what would be useful within the home and women were encouraged to maintain a subservient temperament. The curriculum favoured men's at the expense of women, elevating men's role in the home and society at large (Bowie, Kirkwood & Ardner, 1994; Coquery-Vidrovitch, 1997; Ipensburg, 1992 cited in Shani 2006). These historical perceptions to women's education have been a major contributing factor to education disparities between men and women as illustrated by the literacy rates of 82.5% to 71.2% respectively[34] and between regions. Regional disparities in the provision of education for girls, corresponds to differences in regional economic and political development in the country[35] and family level attitudes and practices that hinder girl's education. The relationship between education and poverty is quite clear; educated people have higher earning potential and are better able to improve the quality of their lives.

Political representation

Women constitute 52% of the Kenyan population and play an active role in the development of the Kenyan society. As a patriarchal society, the status of women remains relatively low with inequalities and inequities prevailing in many aspects. Women are often marginalized and discriminated against in many aspects, a situation that is reinforced by the existing laws and policies as well as socio-cultural factors. Women are grossly underrepresented in leadership and decision making positions a situation that is exacerbated by their lack of economic resources.

SGBV and Harmful Cultural Practices

FGM, early marriage and wife inheritance are among the harmful cultural practices that contribute to the vulnerability of women and girls[36]. These practices vary widely among different ethnic communities and geographical areas and lead to numerous health risks including complications during birth. Gender-based abuse and violence cause injury and humiliation for women and is a major inhibitor for women's participation in public life, including justice sector institutions[37]. Violence results from power imbalance between men and women.

Insecurity

During periods where sections of the country experience conflict and tensions either ethnical or politically motivated, women and children get affected disproportionately compared to the men. Many rights violations and deprivation occur such as rape, loss of livelihoods, loss of property and life. Women also end up with the responsibility of caring for family members and are often faced with the realities of lack or meagre resources at their disposal.

The **underlying causes of poverty** relate to the underpinning and structural causes of poverty and vulnerability for women and girls.

Political system

Regional inequalities in access to services and resources have their roots in colonial policies, and division of administrative units along ethnic boundaries. Subsequent post-independence governments consolidated this ethno-political structure by aligning parliamentary constituencies

[34] KNBS 2008/9
[35] Abagi,1997
[36] Kenya Demographic Health Survey, 2003
[37] UNDP, 2007

with ethnic boundaries, which has remained the style of Kenyan politics and civic administration to date (Schech and Alwy 2004, 265). Ethnic alliances continue to be reinforced through Kenya's political system which focuses on maintaining political support within one's constituency rather than focus on national public interest, this narrow focus has tended to exacerbate ethnic differences and consequently regional inequalities, even as the long term distribution of resources along ethnic lines compounds these disparities (Weinreb 2004).

Ethnic conflict
Ethnic conflict is perpetuated by the need of different communities consciously or unconsciously to gain dominance and hegemony in an atmosphere characterised by scarce resources, fear and prejudice. The proliferation of ethnic conflict affects all communities in the country.

Resource based conflict
Another form of conflict arises from the distribution of resources and a diminishing resource base. Increasing land fragmentation, encroachment of the desert, scarcity of water and environmental degradation continue to exert pressure on the productivity and the lands capacity to sustain life.

Systemic discrimination in access to and control over resources
Under customary law and cultural practices, productive resources such as land, animals and money belonged to the men and women were only allowed to use what was allocated to them, and were often required to seek guidance from the men or community elders on how to use the resources. Punitive practices such as divorce, fines or physical discipline were meted against any woman who seemed to deviate from already established rules and practices. This situation was also upheld by the laws of the land that did not recognise women's rights to matrimonial property creating a barrier to women's economic independence. The land tenure system significantly contributed to discrimination through communal land ownership.

Environmental degradation
Demands on the land for economic development and pressures from a fast growing population have contributed to unprecedented changes in land use that compromises its productivity. Poor farming practices, land fragmentation, and cutting down trees for fuel wood are among the leading causes of environmental degradation.

Climate change
Climate change contributes to land degradation and to factors at the immediate and intermediate level. Increasingly unpredictable weather and environmental degradation lead ultimately to diminishing levels of productivity and greater food insecurity.

4.2.2 Impact Group

CIK began its shift to a programmatic approach in 2010 when it initiated a series of studies on the underlying causes of poverty in different household areas of the country. These studies helped staff to understand and focus on the structural and systemic causes of poverty and social inequity in Kenya. Building on the research and analysis done by staff in Nyanza, northern Kenya including the Dadaab refugee camps, CIK identified an impact group and four sub-impact groups around which to build its work.

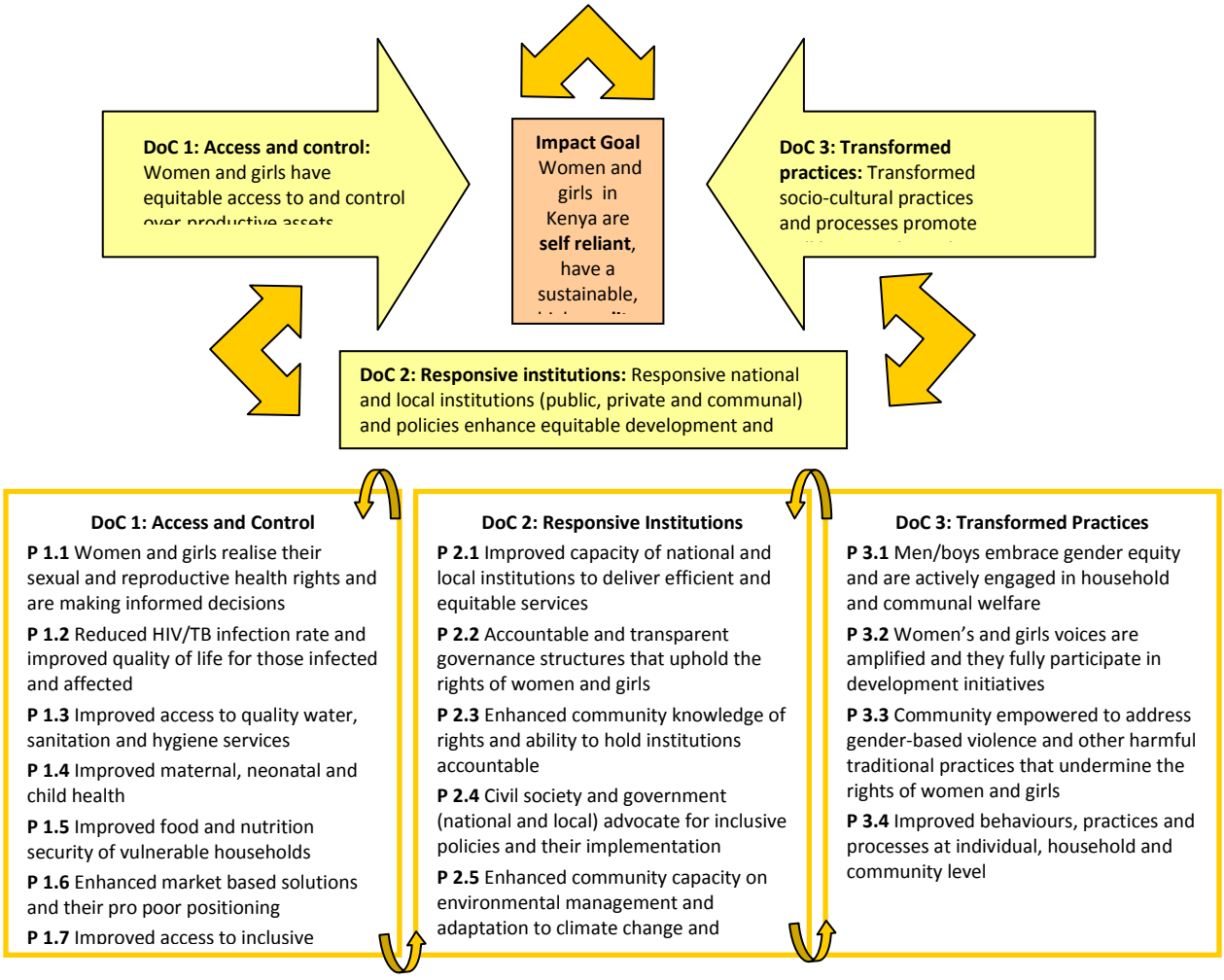
CARE Kenya's impact group is: **Chronically livelihood insecure women and girls constrained by lack of access to and control over productive assets, basic services and denial of rights living in urban informal and rural settings.**

The overall impact group is further subdivided into four sub groups:

- Young girls (youth aged 12-18 years) living in slums,
- Women displaced by natural disasters or conflict
- Out of school girls (12-18) living in rural areas,
- Female headed households with no or limited access to and control over productive assets

4.2.3 Theory of Change

The graphical representation below summarises CARE Kenya's theory of change and demonstrates how CIK conceptualises change for its impact group.



CIK has developed a theory of change that articulates an overarching impact goal and three areas of change required to improve the situation of women and girls in the country. We envision that by 2030, **women and girls in Kenya will be self-reliant, have a sustainable, high quality of life and fully realize their rights** when a) they have *equitable access to and control over productive assets, services, opportunities and benefits,* b) *institutions at local and national level, have policies and practices in place that enhance equitable development and*

resilience of women and girls, and c) *socio cultural practices and processes promote women and girls' well-being and equality*.

CIK is cognisant of the need to work with our partners on each of these areas in order to make a sustainable impact on poverty for our impact group. In order to do this, we must change our project focused approach to one where we address each area, and this requires multi-sectoral programmes, which have a longer implementation period and ensure sustainability through enhanced partnership, advocacy and policy change, and increased accountability. This is an ambitious and complex vision and we will need to continue working within the confines of project based funding, but we will seek to shift our programming towards the larger, longer-term vision we have.

4.2.4 Risks and Assumptions

Insecurity: Recent political developments and cross-border security interventions coupled with economic instability have contributed to increasing incidences of insecurity and crimes in major cities and towns.
National and local institutions in charge of security will contain security risks and enhance protection of communities and citizens.

Political and Economic Instability: The financial crises from Europe to Japan created a ripple effect on all economies globally, coupled with continued wars and civil unrest in many countries creating political and economic instability.
There will be political and economic stability, globally and nationally to support economic development and peace.

Constitutional Reforms: Majority of the reforms envisioned in the new Constitution of Kenya are set to take effect with the new government dispensation.
The new constitution is implemented in the spirit it was created and results in accountable and efficient allocation of resources at various levels.

Development Assistance: There has been a decline in external funding for development aid (Official Development Assistance) with increasing demand for accountability and demonstration of aid effectiveness.
Continued support and increased financial investment for international and national frameworks and agreements with a special focus on gender equality.

National and organization management capacity:
Government and other partners have capacity to manage cyclic emergencies and development initiatives
There is a shared vision, commitment and continued support by partners, GoK and donors.

4.3 Programmes

4.3.1 Livelihood

4.3.1.1 Agriculture Value Chains

The Agriculture Value Chains programme will undertake value chain development by identifying and developing new market opportunities, upgrading high-potential agricultural (crop and livestock) value chains and building market linkages, organizing and supporting agricultural

producers to meet new market requirements and improving the agricultural policy/enabling environment. The program will adopt a value chain approach where smallholder crop and livestock farmers/pastoralists and fisher folk will be linked to markets, finance, inputs and equipment credit services and information. The program will build the capacity of smallholder farmers/pastoralists to increase the efficiency of their value business with improved production and post-harvest handling practices that include improved and diversified seed varieties, improved livestock breeds and range management techniques, value-addition/product diversification, access to quality agro-vet inputs, water for production, and market access.

The program will adopt a "value chain approach" to climate resilience within which special focus will be given to local communities especially women and the natural environment because of their essential roles within enterprise/agricultural value chains. This will also involve creating a better understanding by actors along the value chain of climate-related risks throughout their value chains, identify where emerging market opportunities exist, taking into account community needs, and developing plans that are integrated throughout the enterprise so as to receive the support of communities and civil society.

4.3.1.2 WASH

The Water, Sanitation and Hygiene programme will focus on improving the health and quality of life for chronically vulnerable women, girls and boys in both urban areas and rural locations. This will be achieved through increasing their access to safe water and basic sanitation, promoting improved hygiene behaviour and creating sustainable service structure through improved governance and private sector engagement. For both water and sanitation services, support will be given to activities establishing demand-led services and using technology suited to local conditions and local supply chains. This will help communities access the services they need, provide economic growth opportunities for local people, encourage private sector investment and promote sustainable services. The programme will also focus on water sanitation and hygiene in schools and other institutions providing a unique opportunity to build and share knowledge on the importance of having access to safe water, and basic sanitation and to follow good hygiene practices including menstrual hygiene management. The programme will use information and data gathered to influence policy around school WASH. The programme will take on an integrated water resource management approach to provide a coordinated, participatory and transparent process that promotes sustainable development and use of water resources.

4.3.1.3 Climate Change

Kenya is vulnerable to effects of climate change as evidenced by increased frequency of floods, prolonged droughts, unpredictable rainfall patterns and its subsequent threat to food security. Smallholder farmers and pastoralists are particularly vulnerable to changes in the climate that reduce productivity and negatively affect their weather-dependent livelihood systems. Emerging evidence shows that women and girls experience an even greater inequality through the impacts of climate change. CARE Kenya will work with communities to participatory identify and promote climate change adaptation strategies for implementation. In partnership with relevant government ministries and CBOs, the programme will ensure capacity building of farmers and other civil society organizations to adopt and promote these strategies. It will also ensure the climate information is delivered in a timely to intended users to help them make informed decisions on their livelihood options. It will also work with policy makers to raise their awareness on climate change to influence development and implementation of appropriate adaptive policies and strategies.

4.3.2 Financial Inclusion

4.3.2.1 Access to Financial Services

Access to financial services improves people's lives, in particular those of the poor. Mobilizing savings and accessing credit can make a great difference to a low income family. Access to financial services enables people to invest in income generating activities, better nutrition, and education of their children, housing and health. Many Kenyans and especially in the rural areas remain unbanked with formal financial institutions having high branch concentrations only in urban and high potential areas. Many micro and small scale enterprises and entrepreneurs and especially women face severe financing constraints. But with access to financial services women can participate fully in economic life of their societies, create employment and realize their full potential. In the next five years CARE is going to deepen access to financial services through group savings and loan (GS&L) methodology in Kenya. This will be done through capacity building groups in savings mobilization and access to credit from personal savings. CARE will also work with mature savings groups, formal financial institutions and mobile network service providers for bank linkage through mobile technology to address the challenge of poor infrastructure. CARE will achieve this through partnering with donors and the government for expansion and deepening outreach to the rural and informal settlement areas. CARE will also partner with banks and network service providers for development of pro-poor savings and credit products. To enhance this, CARE plans to embed financial education to groups before bank linkage.

4.3.2.2 Enterprise Development

Micro and small scale entrepreneurs (MSEs) face a myriad of barriers that range from poor social background, lack of business management and skills training as a preparation for entry into MSEs, and socio-economic discrimination (Njeru and Njoka, 1998; Mutuku et al., 2006). The situation is worse for disabled women entrepreneurs who have low self-esteem and view their disability as inability, even in MSE's. Kibas (2006) identified lack of opportunities for management training, financial management, marketing and people management, to be limitations facing micro entrepreneurs. CARE's experience in developing micro- and small-enterprises (MSEs) underscores the importance of locally adapted market-based approaches for their sustainable growth. The selection, planning and management (SPM) and advanced business training using 'improve your business' (IYB) approaches will enhance the capacity of potential and existing entrepreneurs in business initiation and management. CARE will partner with the government and other development agencies in technical skills training and value addition at the community level. CARE will particularly work closely with county authorities for establishment of conducive markets for local trading. Marketing and market linkages will play a key role in enterprise development along the different value chains. CARE will invest in capacity building to local structures in the form of business advisory service providers at the local level for sustainability purposes.

4.3.3 Health

4.3.3.1 Maternal, Neonatal and Child Health

Millennium Development Goals (MDGs) 4 and 5, concerning child and maternal mortality are the two goals with the least progress made globally and in Kenya. While global, regional and national policies and strategies to improve maternal, newborn and child health (MNCH) exists and interventions to prevent maternal, neonatal and child deaths are available in Kenya, MNCH

indicators remain unacceptably poor[38]. The 2008/9 Kenya Demographic and Health Survey indicated a reduction in infant mortality from 77 to 52/1000, reduction in under five mortality from 115 to 74/1000, reduction in new born mortality from 33 to 31/1000, increase in skilled delivery from 42 to 44%, increase in family planning contraceptive prevalence from 39 to 46% AND a decrease in maternal mortality ratio from 414 to 410/ 100 000.

Key focus areas for improving maternal, neonatal, and child health outcomes remain focused antenatal care (FANC), skilled birth attendance, essential newborn care and post-partum care along the continuum of care. CARE advocates for strengthening both community as well as facility initiatives to support increasing uptake of these interventions. Prevention and management of common childhood illnesses at the community level through the Government of Kenya's community health strategy and other community level structures, aimed at attaining universal coverage of cost-effective maternal and child survival interventions. CARE will work with Government, communities, partners and stakeholders for increased access of MNCH services, enhanced capacity of health facilities and health workers, outreach services, immunization, focused antenatal care, prenatal and postnatal services. CARE will also focus on promoting integrated approaches to behaviour change at the community level for MNCH including active men engagement, promotion of infant and young child feeding practices as well as advocacy and support to appropriate MNCH policies.

4.3.3.2 Sexual Reproductive Health

Despite the health sector reform's advances and strategies, there continues to be little progress towards achieving the desired Sexual and Reproductive Health (SRH) indicators as prioritized by the Kenyan Reproductive Health policy framework. The contraceptive prevalence rate (CPR) among married women stands at 46% for modern methods, with a big unmet need in family planning of 21%. Kenya's total fertility rate (TFR) is up at 4.6 from 4.7 in 1995-7, meaning women are generally having more children, which adds to Kenya's rising population, poverty levels and increasing numbers of maternal deaths. Kenya's maternal mortality rate (MMR) has also dramatically failed to improve – now at 448 maternal deaths per 100,000 live births with high regional disparities with north eastern recording as high as 1000 maternal deaths per 100,000 live births. This figure is far off the National Health Sector Strategic Plan III target of reducing MMR to 170 live births per 100,000 by 2015 and the MDG 5 target of reducing MMR to 147 maternal deaths per 100,000 live births or less by 2015. Currently new efforts have been rolled out to address declining indicators including free maternity care, equipping of maternity units and operation theatres to hospitals in hard to reach areas, integrating maternity care with community health services through the community strategy, strengthening referral systems and capacity building of health workers on Reproductive Health (RH) as well as enhancing equitable access to RH services.

CARE in partnership with communities, the Government of Kenya, private sector and other stakeholders, will advocate against retrogressive cultural and religious practices that undermine SRH – including female genital mutilation (FGM) and early marriages, blind generational change of harmful socio-cultural practices through social change and advocate for implementation of comprehensive SRH policies. CARE also intends to contribute to increased access to RH services and enhanced awareness thus addressing the four delays to skilled maternity care. These will include development of relevant evidence based behaviour change methodologies for communities and social analysis and action strategies.

[38] http://www.vsojitolee.org/Images/VSO%20MATERNAL%20AND%20CHILD%20HEALTH_tcm82-37876.pdf

4.3.3.3 HIV, AIDS and Tuberculosis

Since HIV and AIDS first appeared in 1984 in Kenya, the epidemic has exacted an enormous price to the people of Kenya, with major impacts on the country's initiative and efforts for health, social and economic development. As of December 2011, 1.6 million Kenya's were living with HIV. With HIV-infected individuals living longer as a result of increased treatment access, Kenya projects that the number of people living with HIV will continue to grow, placing continuing demands on health and social service systems[39]. Today, there is considerable good news in the war against HIV and AIDS in Kenya. Adult HIV prevalence in 2010 (6.2%) is about 40% lower than at the epidemic's peak. The number of new HIV infections among adults in 2010 was less than one-third the numbers reported in 1993, when the country's epidemic peaked. An estimated 49,126 people died of AIDS-related causes in 2011, slightly more than one-third the annual numbers who died in 2002–2004. Today, Kenya has embraced the goal of ensuring universal access to HIV prevention, treatment, care and support. Attaining this goal is essential to usher in the vision of a world with zero new HIV infections, zero AIDS deaths, and zero AIDS discrimination. Today, CARE remains a key player in Kenya's HIV prevention, care and treatment initiatives, working with communities, the Government of Kenya and various stakeholders including the Global Fund and the US Center of Disease Control and Prevention.

Tuberculosis remains a major global, regional and national health problem, causing ill-health among millions each year and is the second leading cause of death from an infectious disease perspective worldwide after HIV[40]. Globally, the Millennium Development Goal (MDG) target to halt and reverse the TB epidemic by 2015 has already been achieved. New cases of TB have been falling for several years and fell at a rate of 2.2% between 2010 and 2011. The TB mortality rate has decreased 41% since 1990 and the world is on track to achieve the global target of a 50% reduction by 2015. However, the global burden of TB remains enormous, with 80% of the global burden falling in only 22 countries. Kenya is ranked 13th among the 22 high TB burden countries and currently has an estimated 2,300 MDR-TB patients[41].

Malaria is the leading cause of morbidity and mortality in Kenya, with an estimated 25 million out of a population of40 million Kenyans are at risk of malaria. Malaria accounts for 30-50% of all outpatient attendance and 20% of all admissions to health facilities. An estimated 170 million working days are lost to the disease each year[42]. Malaria is also estimated to cause 20% of all deaths in children under five[43]. The most vulnerable group to malaria infections are pregnant women and children under 5 years of age.

CARE will work with communities, civil society organizations, the private sector and the Government of Kenya to reduce new HIV and TB infections, enhance care, treatment and support to the infected and affected persons with respect, acceptance and protection; whilst promoting HIV – TB integration. Further, CARE will focus on reducing socio-economic impacts of HIV and AIDS at household and community level including among orphans, vulnerable children, women and girls while reducing stigma and discrimination and enhancing partnership and advocacy to address underlying causes for HIV, TB and malaria. Capacity building and systems strengthening remains a key area of focus for health service providers, community level organizations as well as communities. CARE will also work with various stakeholders to ensure enhanced prevention, care and treatment of malaria.

[39] NASCOP, The Kenya AIDS epidemic update 2012
[40] World Health Organization, Global Tuberculosis Report 2012
[41] http://www.kenyaforum.net/?p=8558.
[42] Ministry of Health, 2001
[43] Ministry of Health, 2006

4.3.3.4 Sexual and Gender Based Violence

In recent years, there has been increasing concern about gender based violence against women and men which were earlier unreported and in particular domestic violence in Kenya. Not only has domestic violence against women been acknowledged in Kenya and worldwide as a violation of basic human rights, but increasingly research highlights the health burdens, generational effects, and demographic consequences of such violence[44]. Gender-based violence occurs across all socioeconomic and cultural backgrounds. In many societies, women are socialized to accept, tolerate, and even rationalize domestic violence and to remain silent about such experiences. Statistics indicate that Nyanza tops the list of all forms of violence whereby physical is at 56%, sexual 31.6%, and emotional 38.7%; while for women as the perpetrators in Western and North Eastern top the list at 5.2%. Violence of any kind has a serious impact on the economy of a country; because women bear the brunt of domestic violence, they also bear the health and psychological burdens. Victims of domestic violence are abused inside what should be a secure environment–their own homes. To stop some of this violence, which may cause great physical harm, death, psychological abuse, separation, divorce, and a host of other social ills, the Kenya government has enacted the Sexual Offences Act No. 3 of 2006 (Rev. 2007) ,the children act and developed the national guidelines on management of GBV in Kenya. CARE with the support of other relevant agencies will strive to facilitate implementation of such policies and community sensitization; to end the silent suffering when such acts have been committed. Secondly it will try to align her core interventions to help women and girls who bear the brunt of such acts with basic skills to empower and enable them access productive assets and health services and rights.

4.3.3.5 Non- Communicable Diseases

Non Communicable Diseases (NCDs) disproportionately affect low and middle-income countries where nearly 80% of NCD deaths – 29 million – occur. They are the leading causes of death in all regions except Africa, but current projections indicate that by 2020 the largest increases in NCD deaths will occur in Africa. In Africa, deaths from NCDs are projected to exceed the combined deaths of communicable diseases, nutritional diseases, maternal and prenatal deaths as the most common causes of death by 2030[45]. NCDs pose major public health concerns in Kenya causing over 50% of all hospital deaths and admissions and will contribute to over 60% of the total national mortality by 2030. The leading causes of deaths due to NCDs include cardiovascular diseases (13%), cancers (7%) and diabetes (4%)[46].

CARE's focus for NCD's prevention, care, support and treatment include advocacy for affordable quality treatment and care, advocacy for increased investment at all levels for NCDs, capacity building of health workers and systems to enhance prevention, screening, treatment and care, enhancing positive behavioural practices as relates NCDs, advocacy for and supporting the formulation of supportive policy framework for NCDs, support to localized research and development as well as advocate at donor level and other corporate institutions to support cancer, diabetes interventions as well as other NCDs.

4.3.4 Humanitarian Assistance and Emergency

Emergency preparedness involves a functioning emergency response management structure; a well articulated and widely shared response plan that is informed by and is also used to inform the overall CO strategic plan and program approach; a review mechanism in place to perform

[44] United Nations General Assembly, 1991
[45] http://www.who.int/mediacentre/factsheets/fs355/en/
[46] Ministry of Public Health and Sanitation, 2010

frequent reviews of preparedness actions; a reflection process to allow long-term programming efforts to adapt as necessary to address potential risks and disasters, and gender balanced ERT who understand the plan and their roles in it. At the onset of emergency, the program will ensure women, girls, boys and men are consulted during needs assessments, understand the social and cultural context of the affected populations and document sex and age disaggregated data.

Partnership is increasingly being used in emergencies in order to deliver much needed assistance to those most in need and it is clear that partnerships will become a key building block and form an integral part of future humanitarian responses in CARE Kenya. Building on the existing best practices in partnership in emergencies and reinforcing lessons learned from the most recent emergencies in the Horn of Africa, the sector seeks to establish the necessary framework and tools in order to ensure that CARE as an organization is well-positioned to be a lead agency for delivering effective and timely emergency response in Western, Upper Eastern and North East counties. The program has already engaged partners in its emergency preparedness and planning and would therefore strengthen these relationships to increase the speed of the response, increase access and reach, add technical resources, knowledge, and experience; and enhance CARE's own legitimacy. In order to enhance the effectiveness of CARE's humanitarian action, and in recognizing that diversity is an asset in the humanitarian community, the sector is committed to building and nurturing effective local partnerships and networks.

4.3.5 Refugee Assistance Program

The RAP program will focus its interventions on water, sanitation and hygiene by enhancing the capacity of the refugees to undertake maintenance of the water supply systems, improving water quality, enhancing awareness on waterborne diseases prevention and engaging in a sustainability pull out strategy in environmental health; education through teachers training and in gender and community development by providing counselling for refugees especially those considering returning to their countries of origin and enhancing male involvement in GBV interventions.

4.4 Crosscutting themes

4.4.1 Resilience

Vulnerable communities and households could be characterized as those who are one shock away from disaster. Resilience is understood to be the opposite of vulnerability. Therefore resilience is becoming an increasingly used "lens" for humanitarian and development work in situations of recurrent shocks and crisis, as communities are made vulnerable by their process of recovery from the last shock and the imminence of the next to take their little gains away again. As such, 'business as usual' humanitarian activities are repeatedly required in the same locations, yet they don't offer people the next step on the ladder towards long term recovery because all too soon the next disturbance knocks people back down the ladder again. Likewise 'business as usual' development programming fails to hold onto hard-won development gains when the situation deteriorates again. What is needed from a resilience-building approach is a means to provide basic needs (*where they are lacking*) and to secure those basic needs against disturbance. This should be implemented within a framework that feeds into longer term sustainable development goals by providing a secure basis on which households and communities can build their future without risk of losing everything.

As part of working in partnership with other countries within the horn of Africa (defined by CARE as Kenya, Ethiopia, Somalia and South Sudan), we have agreed to use a resilience approach to achieving sustainable and long-term improvements in the lives of the poor. For pastoralist communities/areas, this approach is being consolidated into a sub-regional strategic resilience results initiative (SRRI). Once completed, the SRRI will be a policy framework for programming in arid and semi-arid areas of Kenya.

Within the terms of CARE Kenya's UCP and program approach, we clearly need to address all three domains of change, not just the human condition, as was the case in the past. In particular, we need to ensure that program design is focused on our impact groups. This means that we will actively review and amend project designs to address social position and enabling environment issues in order to enhance resilience of target communities. Resilience is clearly not a program-specific theme, but cuts across all of our work. Building resilience means reducing the vulnerability of communities and the enabling environment that they live in. All sectors of CARE Kenya's program will be supported to review project interventions through a resilience lens, in order that we maximize the impact of our work. M&E systems will be similarly reviewed to include indicators of resilience in their design.

4.4.2 Gender and Women's Empowerment

Gender refers to the rules, norms, customs and practices through which the biological differences between males and females are transformed into social differences between men and women, boys and girls. These socially constituted gender differences are not neutral but result in women/girls and men/boys being valued differently and having unequal opportunities and life chances. These gender differences result in unjust distribution of resources so that some social groups are not recognised as valuable and deserving enough or because what they need is not recognised by those allocating resources, and are reinforced through gendered division of labour (*the tasks and responsibilities that are assigned by social norms to women and men, girls and boys*) and gendered distribution of resources (*the resources that women and men/ girls and boys have access to and control over*). Lack of recognition and value for these groups undermine their self worth and lead to social exclusion.

CARE Kenya seeks to promote gender equity and diversity in line with CARE's vision and mission. This is a vital component of CARE's work to address the underlying causes of poverty that impinge on behaviour, attitudes, practices and policies. Recognition of these social and institutional differences means that in our programming, we will ensure that we review the causes of poverty for women, men, girls and boys as poverty affects these different groups in different ways. When designing project interventions, we will ensure that we will recognize the different ways that project interventions affect different groups, and we will specifically include activities to enhance gender equity and to increase participation and inclusion of different groups of people.

4.4.3 Rights Based Approaches

CARE has embraced a rights based approach to poverty elimination for many years. Rights-based approaches are anchored on human rights i.e. the fundamental moral and legal entitlements that pertain to basic wellbeing and dignity. They are also describes as the "social and political guarantees necessary to protect individuals from the standard threats to human dignity posed by modern state and modern markets" (Donnelly, 1989). Human rights are enshrined in various legal documents and articles such as the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights (ICESCR), the

International Covenant on Civil and Political Rights (ICCPR), the Convention on the Rights of the Child (CRC), the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and the International Convention on the Elimination of all Forms of Racial Discrimination (CERD).

Rights based approaches recognize that by signing the human rights treaties, States are the principal duty bearers with the obligation to respect protect and fulfill all human rights committed to for all citizens. Fulfilling human rights therefore require that the government facilitates, provides and/or promotes these rights, but not necessarily directly meeting all people's socio-economic needs. All human beings have universal and inalienable rights, and as right holders, they are not passive recipients but active subjects expected to demand their rights whether individually or collectively and with the responsibility to participate in the fulfillment of these rights. Other actors such as organizations and individuals also have the moral obligations to respect, promote and protect human rights by emphasizing on participation in development work, transparency in budgetary processes in the effort to promote good governance and promoting attainment of a reasonable standard of wellbeing for all citizens. The rights based approach (RBA) recognizes the intrinsic link between poverty and human rights at policy and strategy levels and ensures that development efforts address the broad concepts of poverty and poverty reduction. It also aims at strengthening the duty bearers to fulfill their obligations and, empowering the right holders to invoke their rights.

5 Strategic Directions

CARE Kenya's goal over the next five years focuses on changing its current operating model to one that places greater emphasis on quality partnership and collaboration with others, and shifts the organizations focus from access and control to fostering more responsiveness in national and local institutions and transformed practices. CARE has adopted four strategic directions that will enable it achieve this goal: partnership, advocacy and policy, knowledge management and learning, and organizational evolution.

5.1 Partnership

Partnership is at the heart of CARE International's programming principles and is an essential strategy for achieving CARE's vision for 2020. CARE's aim to tackle the underlying causes of poverty and social injustice requires making transformative changes in society that CARE cannot achieve on its own. It will require mobilizing people and ideas and working together with civil society organizations, government and communities. In order to achieve this kind of change, CARE Kenya expects that a significant proportion of its programme initiatives will be implemented in partnership with others, building on our commitment to work through, build capacity of, and work alongside partners in strategic ways that yield greater impact.

In our efforts to achieve greater impact in the lives of women and girls, CARE Kenya will build alliances and partnerships with those who offer complementary approaches, are able to adopt effective programming approaches on a larger scale, and who have the responsibility to fulfil rights and reduce poverty through policy change and implementation. CARE recognizes that there is great potential to learn from its partners' strategies and approaches to empowering women and girls, and tackling social injustice.

CARE Kenya is not starting from scratch in terms of partnership. However, many of our current partnerships can be characterized as subcontracting relationships. CARE Kenya also works in

consortia with national, international and UN organizations to advance a range of common objectives (Arid Lands Recovery Consortium, Millennium Water Alliance, ASAL Alliance, Hunger Safety Net programme, Global Fund programme), and is engaged in a public private partnership that works with local producers and Kenyan and Danish private sector food companies. CARE Kenya also has private sector partnerships with a number of financial institutions both within Kenya and internationally.

Over the next five years CARE Kenya will seek to strengthen its own capacity, and those of its partners, to partner more effectively, diversify the number and type of partnerships, and learn from its partnership experiences to improve the impact of its programmes. Key to this change will be further review of how we can be a better partner to those we work with.

Partnership Objectives:

1. Design a **partnership framework** that recognizes the variety of partnerships that exist (from local to global and funding to non-funding) and their respective value in yielding greater impact. The framework will enable CARE Kenya to critically assess its own capacity to partner, as well as the capacity of potential partners, to help guide strategic decisions on partnership. The new partnership framework will place mutual respect, transparency and accountability at the forefront, and drive CARE Kenya to operate in a spirit of openness, flexibility and learning. CARE Kenya will seek to avoid duplicating or competing against the efforts of local and national institutions and instead will aim to add critical value to their efforts through facilitation, brokering of relationships, and capacity building.
2. Develop **partnering as a core competency** within the organization by investing in staff capacity to develop and manage successful partnerships. CARE Kenya will build technical expertise in partnerships that can provide guidance and advice on best practices, strategies and tools. CARE Kenya will draw on the support of CARE Canada and CARE International who have developed expertise in partnerships.
3. Build **capacity of local partners** through its projects and programmes. CARE Kenya will ensure that capacity building strategies are included in programme and project designs. Partner capacity is of particular concern in emergency situations, when timelines are tight, needs are high and partners may not have the skills or capacity to respond to the scale of the crisis. CARE recognizes these limitations and will strive to add critical value to the efforts of national institutions to contribute to positive development in the country and respond effectively to needs during emergencies. Our experience in providing capacity building support to humanitarian response by local institutions shows that funding is a continuing issue, and CARE Kenya will need to give greater focus to working with our other partners to maximize the continuity of funding for this capacity building work.
4. Develop **operational protocols** for establishing and managing partnerships consistent with the vision and spirit of the partnership model described above. Partner selection processes will prioritize relationships that strategically advance CARE Kenya's programmatic objectives, a management information system will provide easy access to key information (see KM and Learning strategic direction for more information) and contractual arrangements will take into consideration the varied nature of CARE Kenya's partnerships.

5.2 Advocacy and Policy

CARE intends to contribute to positive policy changes that transform the way the society works and addresses poverty, marginalization and inclusivity in development. As CARE strives to address the underlying causes of poverty and social injustice, it can no longer only deal with the symptoms of poverty but must influence the governmental and institutional policies and

practices that perpetuate poverty and social injustice. Achieving change in this area requires changes not only in policy but in the democratic space available for dialogue between governments and civil society, and the social norms and practices that influence the extent to which policies can be implemented. CARE recognizes that poverty and discrimination are influenced by decisions at the household level and by decisions made within community leadership structures, all levels of government, national and international organizations, the media and powerful institutions. Changes in these institutions, along with greater transparency and accountability at all levels, are essential for social transformation.

Advocacy Objectives:

1. **Develop an advocacy agenda for each programme** – CIK will articulate an advocacy agenda for each programme and integrate advocacy objectives and activities into key programme initiatives. Some examples of advocacy activities include: research to document evidence of need for policy change; advocating for adoption of new (or changes to existing) legislation; pushing for implementation of policies/legislation; public education on rights and obligations; public campaigning or mobilizing to raise awareness of the need for change in policy and/or practice; capacity building for partner organizations on influencing policy. A key area for increased advocacy is in supporting civil society in monitoring implementation of policies and demanding accountability from political leadership at all levels.
2. **Strengthen advocacy capacity among key staff in the organization** – CIK will invest in improving the technical capacity of staff to develop and implement advocacy strategies, particularly in coordination with our civil society partners. CARE will also seek to recruit staff with experienced in integrating advocacy into programming.
3. **Establish organizational advocacy strategy on the effective inclusion of women in the new constitution and Kenya's vision 2030** – CIK will work in coordination with its partners to develop an advocacy strategy aimed at furthering women's progress and effective inclusion in the context of the new constitution and Kenya's vision 2030.

5.3 Knowledge Management and Learning

CARE International in Kenya will establish the culture, systems and processes to create, manage and share organizational knowledge. Over 44 years of working on innovative programmes in Kenya, CARE has actively learned from its experiences and improved its programming. However, this learning and improvement has not been systematic, in large part because we have not had the knowledge management policies, systems and procedures in place to guide staff's efforts to learn and innovate. Instead, knowledge management has tended to be ad hoc and driven primarily by particular monitoring and evaluation needs. This approach limited CARE Kenya's ability to create, share and use knowledge to bring about positive change in the vulnerable communities where we work.

CARE International in Kenya operates in a complex development environment grappling with issues of urban poverty, vulnerability to climate change and the consequences of political and environmental instability. The operating environment is highly competitive and CARE is increasingly being asked to provide more impact with fewer resources. Strengthening the way CARE creates uses and shares knowledge will enable CIK to improve its ability to innovate and increase its competitive advantage. KM systems and procedures are expected to improve productivity, effectiveness and impact throughout the organization and help respond to external pressures and needs. Building a culture of learning and knowledge sharing is also expected to increase employee satisfaction and commitment to the organization.

Knowledge Management Objectives:

1. **Establish a knowledge management system that supports CARE Kenya's organizational objectives.** CARE will place equal emphasis on the technology that supports knowledge management and dissemination and the people who generate the knowledge. This will entail getting the most appropriate software for knowledge management, learning and sharing that will serve the needs of the organization and those of our peers and partners. Operational systems will be amended to ensure that knowledge captured is held and disseminated in easily accessible forms. Where possible, the system will be linked to those of other CI members and peer organizations to build an effective knowledge management and learning platform.
2. **Build an organizational culture of knowledge sharing and learning.** The most valuable resource in an organization is the knowledge of its staff. The extent to which an organization performs well will depend, in large part, on how effectively its staff can create and share knowledge and use it to best effect across the organization. Senior managers will provide the leadership required to build a learning culture by adopting and modelling new behaviours and fostering an environment where knowledge sharing and learning is valued. At the same time, individual staff will take personal responsibility for managing and sharing knowledge, and creating formal and informal opportunities to discuss, share ideas and learn from their colleagues. CIK will organize organizational behaviour change learning events, field visits and mentoring schemes for staff. In addition, knowledge management will be incorporated in strategic documents such as strategic and operational plans, recruitment processes, monitoring and evaluation frameworks, annual performance appraisals (APAs), individual performance objectives (IPOs), annual operating plans (AOPs) etc

5.4 Organizational Evolution

CARE Kenya will build the requisite skills, capacities, resources, behaviour and leadership to maximize and support impactful programming for women and girls in Kenya. CARE International's Vision 2020 calls on CARE to achieve greater impact by working programmatically with and through others, by advocating for key policy changes and by working to shift behaviours that act as barriers to transformational change. And at the same time, CI is striving to lighten its footprint so that it can remain flexible and competitive. In order to meet this challenge, CARE Kenya will need to develop a new set of skills and improved ways of working that support a better balance between its current focus on compliance and a more strategic focus on building knowledge and practices that promote innovation and greater impact, and make the local to global connections that influence global decisions.

As CARE Kenya shifts its strategic emphasis to mobilizing people and ideas, it recognizes that its staffs are its most important asset. Early and sustained investment in staff is required to develop the new skills and behaviours they will need to act as advocates, conveners and facilitators, action researchers, networkers, alliance builders, and recognizers of local talent.[47]

Over the next five years CARE Kenya will shift the organizational culture to promote performance and learning, and put in place the organizational structure and processes best suited to enhance CARE Kenya's efficiency and effectiveness in maximizing impact on women and girls.

[47] CI2020

Organization Evolution Objectives:

1. Design and implement an organizational **change management plan** that will put in place the enabling conditions (the most effective structure, processes, people and tools) for CARE Kenya to achieve its vision. The plan would outline role of key leadership members and ensures they have the skills and resources to lead the change.
2. **Develop and align staff capacities** with the technical expertise, skills and behaviours required to meet CARE's changing role. CARE Kenya will put in place staff development plans, identify and build the capacity of high potential staff, and establish recruitment practices that prioritize the new expertise and skills needed. Priority areas for skill development and recruitment include: leadership; monitoring, evaluation, learning and impact measurement; advocacy; programme approaches; and partnership.
3. Adopt an **enabling structure and processes** to support staff to work in new ways whether as part of teams or in their individual work. The new structure and processes would enable effective implementation of CARE Kenya's programmatic approaches, including the requisite policy and advocacy work, and support better engagement with other actors involved in the changes CARE is contributing to.
4. Foster an **organizational culture** that supports open communication, accountability and transparency, learning, leadership and performance, and embraces creativity, innovation and flexibility. The leadership of CARE Kenya, with support from CI and CARE Canada, is vital in making this organizational change.

6 Impact Measurement, Monitoring, Evaluation and Research

Since mid-2008 CARE engaged in a process of transitioning from short term project orientation to longer term programme approach after recognising that addressing the underlying causes of poverty requires a long term commitment. This resulted in the realisation that CARE's traditional ways of measuring results (*by focusing on outputs*) were no longer sufficient and embarked on developing an impact measurement strategy for measuring and tracking CARE's contribution to creating sustainable change in the lives of specific impact groups[48]. With the growing emphasis on the assessment of aid effectiveness, accountability and the need to measure results of development interventions, becoming competent in demonstrating impact is critical for all development stakeholders.

As reiterated in sections above, monitoring and evaluation in CARE Kenya was limited to the donor requirements as stipulated in the IPIA and confined within the individual project framework. M&E initiatives were not conducted at higher level such as program or organizational levels and occurred without any form of inter-sectoral or organisational synergy. Different sectors collected their own data, had their own management information systems (MIS) to support data collection and storage, individual data collection tools resulting in duplication of efforts, high maintenance costs for the individual systems and lack of a centralised system for managing information that would enhance storage and retrieval of information. Whilst this situation did not deter successful implementation of the projects, it was neither helpful in assessing longer term contributions as a result of CARE's work nor in providing aggregated data on the organizations progress.

CARE Kenya is embarking on a process of developing an organisational M&E system as a response to the weaknesses in the current M&E system. The organizational M&E system is intended to support impact measurement initiatives, strengthen monitoring and evaluation at the different levels, co-ordinate monitoring, evaluation, research, learning and capacity

[48] Impact Measurement Readiness Assessment: East and Central Africa Region, 2010

strengthening initiatives with a view of improving the quality of programming. The development of the organizational M&E system will be done through an established technical working group with oversight from the senior management team and support from the program teams. This process will be conducted parallel with the development of comprehensive programs by program teams as indicated in section 4 above. These program documents will serve as a basis for impact measurement, monitoring and evaluation by clearly articulating program specific theories of change, development for relevant indicators and M&E initiatives as well as mobilising resource to support M&E initiatives. The country office will support the development of annual operational plans as constituents of the LRSP and subject these to performance measurement both for accountability and learning. Research initiatives will be undertaken to inform future programming, support evidence-based advocacy and design innovative interventions. Partnerships and collaboration with relevant organisations, government agencies and institutions of higher learning for research will be sought out. Inter-linkages will be created with knowledge management and accountability mechanisms so as to develop a coherent, holistic system and capacities for enhancing impact measurement.

7 Resource Implications

CARE Kenya has traditionally raised funds through grants from large institutions and international development agencies. While this still remains a primary source of funds, it has recently engaged in fundraising from the private sector. With the shift towards program approaches, CARE is looking at also sourcing for flexible funds to support the program shift.

8 Annexes

8.1 Bibliography

CARE Canada (1982, 1983, 1984), *Annual Reports.*

CARE International (2010), *CARE Gender and Diversity Strategy.*

CARE International (2010), *Impact Measurement Readiness Assessment: East and Central Africa Region*, Tom Barton

CARE International (2012), *CARE Vision 2020.*

CARE International in Kenya (2009-2011), *Strategic Plan: Securing Livelihoods of the Poor.*

CARE International in Kenya (2011), *Understanding Poverty and Vulnerability in the Greater Marsabit District of Kenya.*

CARE International in Kenya (2011), *Understanding Programme Shift, Theory of Change and Unifying Framework Workshop Report.*

CARE International in Kenya (2012), *Literature Review: Underlying Causes of Poverty and Vulnerability of Women and Girls in Northern Kenya, Nyanza and Urban Informal Settlements in Nairobi, Kisumu and Garissa.*

CARE International in Kenya (2012), *Long Range Strategic Planning Workshop Report.*

CARE International in Kenya (2012), *Trends and Stakeholder Analysis.*

CARE International in Kenya (2013), *Theory of Change Workshop Report.*

CARE USA (2009), *Impact Measurement Strategy*

Government of Kenya (2003), *Economic Recovery Strategy for Wealth and Employment Creation*

Government of Kenya (2007), *Kenya Vision 2030: A Globally Competitive and Prosperous Kenya.*

Government of Kenya (2009), *Draft National Policy on Disaster Management in Kenya*

Government of Kenya (2010), *National Climate Change Response Strategy*

Institute for Environmental Security (2011), *Environmental Security Assessment*

International Crisis Group (2012), *The Kenyan Military Intervention in Somalia, Africa Report No. 184.*

International Monetary Fund (2012), *World Economic Outlook: Coping with High Debt and Sluggish Growth*

Kenya National Bureau of Statistics (2003), *Geographic Dimensions of Well Being in Kenya,* Vol. II

Kenya National Bureau of Statistics (2003, 2008-09), *Kenya Demographic and Health Survey*

Kenya National Bureau of Statistics (2005-06), *Kenya Integrated Household and Budget Survey*

National Aids Control Council (2012), *The Kenya AIDS epidemic update,* National AIDS and STI Control Programme (NASCOP)

United Nations (2012), *World Economic Situation and Prospects*

World Bank (2009), *Kenya Poverty and Inequality Assessment: Executive Summary and Synthesis Report*

World Bank (2009), *Kenya Economic Update, Still Standing: Kenya's Slow Recovery from a Quadruple Shock,* Ed. 1

World Bank (2010), *Kenya Economic Update, Running on One Engine: Kenya's Uneven Economic Performance, Ed. 2*

World Bank (2010), *Kenya Economic Update, At the Tipping Point: The Implication of Kenya's ICT Revolution, Ed. 3*

World Bank (2011), *Kenya Economic Update, Turning the Tide in Turbulent Times: Making the most of Kenya's Demographic Change and Rapid Urbanization, Ed. 4*

World Bank (2011), *Kenya Economic Update, Navigating the Storm: Delivering the Promise, Ed. 5*

World Bank (2011), *Kenya Economic Update, Walking on a Tight Rope: Rebalancing Kenya's Economy, Ed. 6*

World Bank (2011), *The Drought and Food Crisis in the Horn of Africa: Impacts and Proposed Policy Responses for Kenya*

World Health Organization (2012), *WHO Global Tuberculosis Report*