FINAL EVALUATION REPORT FOR THE PROJECT 'LET IT NOT HAPPEN AGAIN: SAFEGUARDING THE RIGHTS OF GBV SURVIVORS THROUGH ACCESS TO JUSTICE'.

Report

Submitted to UN Women Kenya Country Office

by

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List of Acronyms

Acronym	Full term
AICS	Italian Agency for Development Cooperation
CBO	Community-Based Organization
CPD	Continuing Professional Development
CSO	Civil Society Organization
CUC	Court User Committee
EVAWG	Ending Violence Against Women and Girls
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
GERAAS	Global Evaluation Reports Assessment and Analysis System
GSWG	Gender Sector Working Group
HAK	Healthcare Assistance Kenya
HRBA	Human Rights-Based Approach
HRD	Human Rights Defender
IAU	Internal Affairs Unit

IAWJ	International Association of Women Judges
IPOA	Independent Policing Oversight Authority
KAP	Knowledge, Attitudes and Practices
KCO	Kenya Country Office
KII	Key Informant Interview
KNBS	Kenya National Bureau of Statistics
KNCHR	Kenya National Commission on Human Rights
LNOB	Leave No One Behind
M&E	Monitoring and Evaluation
MTR	Mid-Term Review
NCAJ	National Council on the Administration of Justice
NCPWD	National Council for Persons with Disabilities
NGEC	National Gender and Equality Commission
NLAS	National Legal Aid Service
NPS	National Police Service
ODPP	Office of the Director of Public Prosecutions
OECD-DAC	Organization for Economic Co-operation and Development- Development Assistance Committee
OHCHR	Office of the United Nations High Commissioner for Human Rights
PHR	Physicians for Human Rights
PJI	Partners for Justice International
POLICARE	Police Care
PWD	Person with Disability
SGBV	Sexual and Gender-Based Violence
SOP	Standard Operating Procedure
TFGBV	Technology-Facilitated Gender-Based Violence
ToC	Theory of Change
UN	United Nations
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNSDCF	United Nations Sustainable Development Cooperation Framework
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
VAWG	Violence Against Women and Girls
WEE	Women's Economic Empowerment
WRO	Women's Rights Organization

Executive Summary

PROJECT AND EVALUATION OVERVIEW

UN Women and OHCHR implemented the project, *Let It Not Happen Again: Safeguarding the Rights of GBV Survivors Through Access to Justice*, with funding from the Government of Italy/AICS. The evaluated phase ran from 1 June 2023 to 31 May 2026 across Nairobi, Kisumu, Kilifi, Isiolo, Bungoma and Vihiga counties, alongside engagement with national institutions, civil society organizations (CSOs) and human rights defenders (HRDs). It sought to strengthen GBV prevention and response systems, accountability and coordination, and survivor-centered access to justice and essential services.

The evaluation applied the OECD-DAC criteria of relevance, coherence, effectiveness, efficiency, impact and sustainability, with gender equality and human rights integrated throughout. A theory-based, gender-responsive mixed-methods approach combined document review, KIIs, FGDs and a KAP survey of 183 respondents, including 112 project participants and 71 non-participants. Evidence was triangulated across methods, counties and stakeholder groups, with the evaluation assessing contribution rather than direct attribution.

OVERALL ASSESSMENT

The project made a substantial contribution to strengthening GBV prevention and response systems and improving survivor-centered access to justice and essential services. Its strongest results were in institutional and cross-sectoral coordination, referral systems, practical capacity development, survivor awareness and access to selected services, specialized justice arrangements, and participation of women, HRDs and WROs in coordination processes. The combination of UN Women's gender equality expertise, OHCHR's human rights and accountability mandate, government institutions and community and specialist partners was central to these results.

Progress remained uneven. Persistent constraints included inadequate shelter services, limited access to legal aid, and psychosocial support; geographic and disability-related barriers; justice delays; staff transfers; fragmented data systems; and weak county financing. They limited the translation of stronger institutional capacity and coordination into consistently accessible, adequately financed, and integrated GBV services.

KEY FINDINGS

Relevance. The project was highly relevant to systemic barriers affecting GBV prevention, justice, and essential services. It addressed institutional capacity, fragmented referrals, accountability, survivor support, harmful social norms and economic vulnerability. The three-year implementation period provided greater scope for sustained institutional engagement than the earlier annual phases. Survivor needs for information, counseling, health care, referrals, legal assistance and economic skills were addressed, while access to shelters, transport, sustained legal and psychosocial support remained important gaps.

Coherence. The project was strongly aligned with Outcome 2 of the UN Women Kenya Strategic Note 2023–2026, the UNSDCF Strategic Priority 1: People and Peace, and national and county GBV and justice priorities. It complemented wider UN Women and OHCHR initiatives and worked through existing coordination structures, including Court User Committees, Gender Sector Working Groups and broader engagement on the protection of HRDs and accountability mechanisms, respectively. Complementarity between UN Women and OHCHR was a particular strength, although clearer mapping and attribution of partner contributions would have improved portfolio coherence.

Effectiveness. The project was substantially effective, although results varied. The results matrix reported 78.3 percent of trained actors with increased knowledge, women constituted 62.3 percent of participants in supported coordination mechanisms, and 4,059 women and girls were recorded as accessing comprehensive GBV services against a target of 1,800. However, the reporting does not clearly establish whether the 4,059 figure represents unique beneficiaries or includes women who accessed multiple services and may therefore have been counted more than once. KAP findings showed that 90 percent reported improved awareness of services, 93.9 percent improved knowledge of reporting and referral pathways, and 77.5 percent perceived improved access to justice and essential services. Qualitative evidence confirmed improvements in referrals, counseling, accompaniment and survivor-sensitive case handling. Justice delays, shelter shortages, transport costs, limited forensic capacity and uneven accessibility constrained results.

Efficiency. Efficiency was moderate. The multi-year approach, dedicated staffing, existing institutional structures and complementary partnerships supported delivery across six counties. Annual contracting, disbursement delays, transfers of trained government personnel, uneven geographic reach and weaknesses in results reporting reduced efficiency.

Sustainability. Sustainability prospects were mixed. Institutional skills, relationships, referral practices, policies, justice structures and community networks provide a basis for continuity. 79.5 percent of KAP respondents believed project gains were likely to continue, rising to 88.1 percent among project participants. Sustainability is weaker for services requiring recurrent financing, including counseling, legal aid, transport, shelter and outreach. Transfers and reassignment of trained government personnel, weak county financing, fragmented data systems and reliance on under-resourced HRDs remain important risks.

Gender equality and human rights. Human rights-based, gender-responsive and survivor-centered principles were substantially integrated into the project. Survivors reported respectful counseling, accompaniment, and increased confidence, while HRDs and WROs participated in coordination and accountability processes. Inclusion was less consistent for persons with disabilities and others facing geographic and economic barriers, particularly regarding accessible facilities, sign-language interpretation, adapted information and reasonable accommodation.

Impact. Emerging changes included stronger institutional relationships and referral practices, improved survivor confidence and knowledge, increased participation and networking of HRDs and WROs, and improved knowledge of HRDs on survivor-sensitive case handling. Accountability work strengthened collaboration and experience around complex human rights violations, including the Baby Pendo case, the first of its kind in which police commanders are being prosecuted under command responsibility under international criminal law in Kenyan courts, although proceedings remain ongoing. Economic empowerment contributed to skills, confidence and livelihood opportunities for some women, while evidence of sustained income and longer-term economic security remained limited.

CONCLUSIONS

The project demonstrated the value of combining institutional strengthening, survivor services, accountability, coordination, community engagement, and economic empowerment. Its strongest prospects for continuity lie in institutional relationships, knowledge, referral practices. and established coordination platforms. Sustaining these gains will require stronger institutionalization and public financing, particularly for survivor services and county-level systems.

Future programming should prioritize institutionalizing survivor-centered practice; strengthening county financing; improving integrated legal, health, psychosocial, shelter, transport and follow-up services; strengthening disability inclusion; adequately supporting HRDs, WROs and survivor networks; improving GBV data and results monitoring; and maintaining the complementary roles of UN Women, OHCHR, government and specialist partners.

RECOMMENDATION PRIORITIES

The evaluation proposes seven linked recommendations. Immediate priorities (0-12 months) are to resource and consolidate multi-sectoral coordination and referral systems (R1); strengthen continuity of survivor-centered legal, psychosocial, shelter, transport and recovery support (R2); improve monitoring and disaggregation of inclusion and accessibility outcomes (R3); strengthen and resource HRDs, WROs and community responders (R4); and redesign future results frameworks to track institutional practice, survivor pathways, accessibility and sustainability (R6). A medium-term priority (12-36 months) is stronger national and county public financing and institutional ownership (R5). Any subsequent joint programme should retain the complementary UN Women-OHCHR model with clearer joint planning, contribution tracking and learning (R7). Government institutions are the primary duty bearers for institutionalization and public financing, with UN Women, OHCHR, AICS/development partners and civil society providing technical, convening and implementation support according to mandate.

The primary users of the evaluation are UN Women, OHCHR, the Government of Italy/AICS, national and county government institutions, implementing partners, WROs and HRDs. The findings are intended to support accountability for project results and inform future programming, government institutionalization and financing, partnerships, survivor-centered services, and the design and monitoring of subsequent GBV interventions.

1. Background and Purpose of the Evaluation

1.1 Evaluation background

UN Women Kenya Country Office commissioned this final evaluation of the project '*Let It Not Happen Again: Safeguarding the Rights of GBV Survivors Through Access to Justice*'. Funded by the Government of Italy through AICS, the EUR 1.8 million project was jointly implemented by UN Women and OHCHR, working with government institutions and civil society partners. Substantive implementation ran from 1 June 2023 to 31 May 2026, followed by a two-month no-cost extension to 31 July 2026 for project close-out (AICS Nairobi, 2023).

The project built on three earlier phases supported by Italy between 2019 and 2023. It evolved from an initial focus on violence against women during elections towards addressing broader systemic barriers to GBV prevention, survivor protection, access to justice and essential services. Phase IV expanded implementation from four to six counties and strengthened attention to institutional reform, survivor-centered justice, cross-sectoral coordination, community engagement and women's social, legal and economic empowerment.

The evaluation provides an independent assessment of project performance and contribution across the implementation period and considers changes in Kenya's GBV and access-to-justice context. It was conducted in accordance with the UN Women Evaluation Policy and Evaluation Handbook and relevant UNEG norms and ethical standards (UN Women, 2020; UN Women, 2022a).

1.2 Purpose of the evaluation

The evaluation serves three related purposes: accountability, learning and decision-making. It assesses project performance and resource use, including the project's contribution to stronger institutions, coordination, survivor-centered services, and the protection and agency of women and girls. It also identifies practices, partnerships and contextual factors that supported or constrained results, generating lessons for future GBV programming.

The evaluation also examines programme processes, with attention to participation, inclusion, institutional accountability and survivor safety. It considers intersecting barriers associated with disability, age, poverty and geography, supporting a gender-responsive and human rights-based assessment of project results and implementation.

1.3 Intended users and uses

The evaluation is intended for stakeholders involved in project oversight, financing, implementation and service delivery. Primary users include UN Women Kenya Country Office, OHCHR, the Government of Italy/AICS, national and county government institutions, implementing partners, women's rights organizations and human rights defenders. Survivors and other rights holders are also important users and intended beneficiaries of the findings.

The findings will inform UN Women and OHCHR's future programming, partnerships, resource allocation, monitoring, institutional accountability and work on GBV prevention, access to justice and survivor support. They will support the Government of Italy/AICS in assessing project performance and informing future cooperation, while national and county institutions and civil society partners can use the findings to strengthen policies, coordination, budgeting, referral systems, community engagement and survivor-centered services.

The evaluation also provides evidence on survivors' experiences of accessing protection, services and justice, to inform improvements in the accessibility, safety, dignity and responsiveness of GBV prevention and response systems and survivor-centered services.

2. Programme Description and Context

2.1 Gender-based violence and access to justice in Kenya

GBV remains widespread in Kenya and includes physical, sexual, psychological and economic violence, harmful practices, sexual harassment and technology-facilitated violence. Women and girls are disproportionately affected. The 2022 Kenya Demographic and Health Survey found that 34 percent of women aged 15–49 had experienced physical violence since age 15 and 13 percent had experienced sexual violence. Among women who had ever been married or had an intimate partner, 41 percent had experienced emotional, physical or sexual violence from their current or most recent partner. Only 42 percent of women who had experienced physical or sexual violence had sought help (KNBS & ICF, 2023).

Survivors face interconnected institutional, social, economic and geographic barriers. These include distance and transport costs, investigation and court delays, limited legal aid, shelters and psychosocial support, weak referral systems, and

challenges in medical and forensic evidence management. Stigma, economic dependence, pressure to reconcile and confidentiality concerns can further discourage reporting and continuation through justice processes. These barriers are often greater for adolescents, persons with disabilities, women living in poverty and survivors in remote areas. The Judiciary's SGBV Strategy 2023–2030 recognizes similar constraints and promotes more accessible, specialized and trauma-responsive handling of SGBV cases (Judiciary of Kenya, 2023).

Devolution places important health, social and coordination functions at county level, making county institutional capacity, financing and service infrastructure important determinants of survivor access. The six project counties present different operating environments, ranging from Nairobi's concentration of institutions and providers to rural and dispersed populations in Kisumu, Bungoma, Vihiga and Kilifi and the long distances characteristic of Isiolo.

The context also evolved during implementation. Femicide gained increased public and policy attention, leading to the establishment of a Presidential Technical Working Group on GBV, including Femicide, in January 2025. The Working Group subsequently identified gaps in classification, data, financing and institutional coordination (Republic of Kenya, 2025). Technology-facilitated GBV, including online harassment, cyberstalking, sexualized threats, sextortion and non-consensual distribution of intimate images, also became increasingly prominent. A 2024 study in selected Nairobi tertiary institutions found that 39 percent of participating students had experienced technology-facilitated GBV, although the findings are not nationally representative (UNFPA Kenya, 2024).

The project therefore operated in a context of persistent GBV, relatively low help-seeking, unequal access to justice and essential services, constrained institutional resources and evolving forms of violence against women and girls.

2.2 Policy and institutional setting

Kenya has an extensive legal and policy framework for GBV prevention and access to justice, anchored in constitutional protections for equality, dignity, security and access to justice. Legislation addresses sexual and domestic violence, victim and witness protection, legal aid, FGM, trafficking and technology-facilitated harms. National GBV policies, guidelines and multisectoral procedures provide an operational framework, while the Judiciary's SGBV Strategy 2023–2030 promotes specialized and trauma-responsive justice.

Implementation responsibilities extend across national and county governments, police, health services, prosecutors, the Judiciary and oversight and protection institutions. Coordination mechanisms include national and county Gender Sector Working Groups, Court User Committees, police gender units, POLICARE centers, specialized Gender Justice Courts and referral networks. Civil society, WROs, HRDs and survivor networks complement public systems through awareness, referrals, accompaniment, legal and psychosocial support, advocacy and accountability.

Despite this institutional architecture, implementation is affected by financing, staffing, infrastructure and differences in institutional capacity across counties. GBV data also remain fragmented across police, courts, health facilities, government departments and service providers, with differences in definitions, indicators, disaggregation and data sharing (Republic of Kenya, 2025).

The project operated within and sought to strengthen these existing systems. It aligned with Strategic Priority 1 of the UNSDCF 2022-2026, particularly Outcomes 1.1 and 1.2 on human rights, gender equality, access to justice and inclusive services, and with Outcome 2 of the UN Women Kenya Strategic Note 2023-2026. Its accountability and access-to-justice components also aligned with OHCHR's human rights mandate and engagement with justice, oversight and accountability institutions. The findings chapter assesses the project's contribution within this strategic and institutional framework.

2.3 Project origin and evolution

The project originated from concerns about sexual and gender-based violence during Kenya's elections. A 2019 gap analysis, *Breaking the Cycles: Prevention of and Response to Electoral Related Sexual Violence*, by UN Women, OHCHR and Physicians for Human Rights identified limited institutional preparedness, weak coordination, capacity gaps among duty bearers and inadequate GBV data. Nairobi, Kisumu, Bungoma and Vihiga were selected based on reported violence during the 2017 elections (UN Women, OHCHR, & Physicians for Human Rights, 2019).

With EUR 900,000 from the Government of Italy/AICS, UN Women and OHCHR implemented three phases between 2019 and 2023. The programme progressively evolved from accountability and preparedness for election-related sexual violence towards strengthening cross-sectoral coordination, justice institutions, essential services, civil society and HRDs, while maintaining attention to electoral violence.

The final evaluation of the first three phases found improvements in institutional coordination, electoral early-warning structures and access to services, including training of 314 justice actors and provision of essential services to 2,689 survivors. It also identified continuing gaps in GBV financing, data systems, forensic evidence, shelters, psychosocial support, coordination and sustainability (UN Women, 2024).

Phase IV incorporated lessons from these earlier phases and responded to the evolving GBV context. Funding increased to EUR 1.8 million, implementation shifted to a three-year period, and geographical coverage expanded to Kilifi and Isiolo, bringing the total to six counties. The two counties were selected partly because they were among Kenya's furthest left behind counties, while Kilifi had also recorded particularly high levels of teenage pregnancy during the COVID-19 period. Phase IV retained institutional capacity, accountability and coordination while strengthening legal and policy implementation, survivor-centered justice, essential services and community engagement. It also introduced economic empowerment as a distinct component, linking women's social and legal empowerment with economic recovery and agency (UN Women & OHCHR, 2022).

The project also adapted during implementation to emerging concerns. Technology-facilitated violence was incorporated into judicial capacity development, while growing concern around femicide informed national-level engagement and dialogue, although neither had constituted a distinct intervention pathway in the original design. Phase IV therefore represented a broader programme addressing systemic barriers to GBV prevention, access to justice, survivor support and recovery while retaining the institutional and accountability foundations developed under the earlier phases.

Table 1: Key programme adaptations during Phase IV

Original plan/assumption	Adaptation during implementation	Reason/implication for evaluation
Three-year substantive implementation to May 2026	Two-month no-cost extension to 31 July 2026 for close-out	The evaluation distinguishes substantive implementation ending 31 May from administrative close-out through 31 July.
Four-county legacy footprint from earlier phases	Expansion to Kilifi and Isiolo, bringing coverage to six counties	Broadened geographic diversity but reduced depth of reach in some remote areas; county-level results are interpreted in light of different starting points.
Planned institutional, justice, service and community pathways	Implementation adapted to emerging concerns including femicide and technology-facilitated GBV and to county-specific referral and coordination needs	Adaptations are assessed as contextual responsiveness rather than as separate original result pathways.
Annual partner implementation arrangements within a multi-year project	Partner renewals and some disbursement delays compressed implementation periods	Timeliness and efficiency findings distinguish the value of the multi-year horizon from transaction costs created by annual contracting.

2.4 Project profile and results architecture

The project was jointly implemented by UN Women and OHCHR across Nairobi, Kisumu, Bungoma, Vihiga, Kilifi and Isiolo. Its primary rights holders were women and girls, particularly GBV survivors and groups facing additional barriers to justice and essential services.

Implementation combined the complementary mandates of UN Women and OHCHR with government and civil society partnerships. UN Women provided programme leadership and expertise in gender equality, ending violence against women, coordination and women's empowerment. OHCHR contributed its human rights and accountability mandate, including engagement with justice, oversight and human rights institutions. National and county government institutions were responsible for policy implementation, policing, prosecution, justice, health and other essential services and formal coordination mechanisms. Implementing partners, WROs, HRDs, survivor networks and community actors supported

awareness, referrals, survivor accompaniment, legal and psychosocial support, advocacy and accountability. The Government of Italy/AICS financed the project and provided donor oversight.

The project covered legal and policy support, institutional capacity development, justice and essential services, coordination and referral systems, GBV data and monitoring, community awareness, and women's social, legal and economic empowerment. Its formal results framework comprised two outcomes and four outputs.

Table 2: Results framework

Results level	Intended result
Outcome 1	National and county governments have systems that effectively prevent and respond to GBV and promote the rights of women and girls.
Output 1.1	National and county institutions have the capacity to develop, review and implement GBV policies and plans.
Output 1.2	National and county institutions have enhanced capacity to monitor and report on GBV prevention and response.
Outcome 2	Women and girls are protected from GBV and have access to quality essential services.
Output 2.1	Women and girls are aware of and exercise their rights in relation to GBV prevention and response.
Output 2.2	State and non-state actors have enhanced capacity for cross-sectoral coordination on GBV prevention and response.

Operationally, national-level interventions supported laws and policies, accountability, GBV data and monitoring and justice-sector capacity. County-level interventions worked through government departments, justice institutions, coordination structures and service providers. Community-level interventions included awareness and dialogue, referrals, survivor and medico-legal support, psychosocial services, economic empowerment and financial and vocational skills, working with WROs, HRDs and survivor networks (UN Women & OHCHR, 2022).

2.5 Theory of Change

The reconstructed Theory of Change linked interventions at institutional, community and survivor levels through two interconnected pathways. The institutional pathway proposed that strengthening gender-responsive laws and policies, institutional capacity, coordination, GBV monitoring and accountability would improve the ability of state and non-state institutions to prevent and respond to GBV. The survivor and community pathway proposed that greater awareness and legal literacy, stronger referral systems, survivor-centered services, psychosocial support and economic empowerment would strengthen women's and girls' ability to seek support, exercise their rights, pursue justice and recover from violence. Together, these pathways were expected to contribute to stronger GBV prevention and response systems and improved realization of the rights, safety and agency of women and girls. This reflects the reconstructed ToC developed during inception.

The pathways depended on several assumptions: continued institutional commitment; retention and application of strengthened capacities; functional and adequately resourced coordination mechanisms; availability and accessibility of essential services; and survivors' ability to move through reporting, referral, service and justice pathways. The evaluation used the reconstructed ToC as an analytical framework to test whether these pathways materialized, whether the underlying assumptions held, and how contextual factors affected intended and unintended results. The evaluation matrix similarly tests the plausibility of the pathways linking project activities to Outcomes 1 and 2.

Table 3: Reconstructed Theory of Change

Interventions	Immediate change	Expected outcomes	Higher-level change
Legal and policy support; institutional capacity; monitoring and accountability; coordination	Stronger institutional capacities, policies, accountability and coordination	More effective GBV prevention, response and access-to-justice systems	Improved protection, rights, safety and agency of women and girls
Community awareness and legal literacy; referrals; survivor-centered	Greater awareness, access to services, survivor	Women and girls are better able to exercise	Improved protection, rights, safety and

and psychosocial services; economic empowerment	support, recovery and agency	their rights, seek protection and pursue justice	agency of women and girls

Key assumptions: institutional commitment and staff continuity; adequate financing and infrastructure; functional coordination and referral systems; accessible essential services; and survivor safety and ability to engage with service and justice institutions.

3. Evaluation Objectives and Scope

3.1 Evaluation objectives

The evaluation assessed the project's intended and unintended results in strengthening national and county GBV prevention and response systems and improving survivor-centered access to justice and essential services. It examined the factors influencing performance and generated lessons and recommendations for future programming.

Specifically, the evaluation assessed: (i) relevance, effectiveness and efficiency, including the Theory of Change; (ii) coherence with UN Women priorities, national and county frameworks and related initiatives; (iii) emerging impact and sustainability; (iv) integration of human rights-based, survivor-centered, gender-responsive and inclusive approaches; and (v) priorities for future programming and collaboration with OHCHR and other partners.

3.2 Evaluation scope

The evaluation scope was defined by the Terms of Reference and covered the full substantive implementation period from 1 June 2023 to 31 May 2026. Geographically, it covered Nairobi, Kisumu, Kilifi, Isiolo, Bungoma and Vihiga counties, together with relevant national-level interventions. Institutionally, it covered UN Women, OHCHR, the Government of Italy/AICS, national and county government and justice institutions, implementing partners, WROs, HRDs, survivor networks and community actors.

The thematic scope included policy reform, institutional strengthening and accountability, coordination and referral systems, survivor-centered justice and essential services, community awareness, women's agency and economic empowerment, and the integration of human rights, gender equality, disability inclusion and Leave No One Behind principles. The evaluation assessed planned outputs and outcomes, unintended changes, implementation processes and contextual influences, as well as emerging impact, sustainability and the validity of the reconstructed Theory of Change.

Some dimensions could only be assessed to a limited extent. Access to some remote populations was constrained, while gaps and limited disaggregation in project results and financial data restricted assessment of selected results and efficiency dimensions. The timing of the evaluation around project completion also limited assessment of longer-term institutional, accountability, livelihood and social-norm changes. Survivor consultations examined experiences of services, justice, protection, economic empowerment and perceived change while avoiding unnecessary probing of traumatic experiences in accordance with survivor-centered and do-no-harm principles. These considerations informed the interpretation and qualification of findings and are discussed further under evaluation limitations.

3.3 Evaluation criteria and questions

The evaluation applied the Organization for Economic Co-operation and Development, Development Assistance Committee (OECD-DAC) criteria of relevance, coherence, effectiveness, efficiency, impact and sustainability. Gender equality and human rights, survivor-centered practice, disability inclusion and Leave No One Behind were integrated throughout. The full evaluation matrix is provided in the annex.

Table 4: Evaluation questions

Criterion	Strategic evaluation questions
Relevance	1. Was the project design and Theory of Change responsive to systemic barriers affecting GBV prevention, justice and essential services?

	2. How well did it respond to the needs of women and girls, particularly survivors and people facing intersecting vulnerabilities?
Coherence	3. Was the project coherent with the UN Women Kenya Strategic Note 2023–2026 and UN Women's mandate? 4. How effectively did it complement national and county GBV frameworks, justice reforms and related initiatives?
Effectiveness	5. To what extent did the project strengthen institutional systems, accountability and cross-sectoral coordination? 6. To what extent did it improve survivor-centered access to justice and essential services?
Efficiency	7. How efficiently were financial, technical and partnership resources used? 8. Did implementation and partnership arrangements support timely delivery and value for money?
Sustainability	9. How likely are strengthened institutional systems and coordination mechanisms to continue? 10. How durable are changes in survivor empowerment, accountability and access to services?
Gender equality and human rights	11. How well were human rights-based, survivor-centered and gender-responsive principles integrated? 12. How effectively were disability inclusion and the rights and participation of marginalized groups addressed?
Impact	13. What broader intended or unintended changes emerged? 14. To what extent did the project contribute to systemic or transformative change?

3.4 Scope boundaries

The evaluation assessed the project's contribution to observed changes, recognizing the influence of wider reforms, programmes and social processes. It did not assess GBV prevalence, conduct criminal or clinical investigations, or audit individual cases. Survivor consultations focused on accessibility, responsiveness, dignity, safety and perceived change and did not require detailed accounts of traumatic experiences.

4. Evaluation Methodology and Limitations

4.1 Evaluation approach

The evaluation used a theory-based, utilization-focused, gender-responsive mixed-methods approach guided by the OECD-DAC criteria. Gender equality, human rights, disability inclusion and survivor-centered principles were integrated across data collection, analysis and interpretation. A reconstructed Theory of Change guided assessment of how interventions contributed to changes in institutional capacity, coordination and accountability, survivor access to justice and essential services, community awareness and women's agency. Given the influence of government reforms, other programmes and contextual factors, the evaluation assessed plausible project contribution rather than direct attribution.

The evaluation matrix linked each evaluation question and sub-question to indicators, data sources, methods and stakeholder groups and informed the data collection tools and analysis. The full evaluation matrix planned sampling framework and data collection tools are provided in the Inception Report annexes.

4.2 Data collection and sampling

The evaluation combined document review, KIIs, FGDs and a KAP survey. Primary data collection was conducted between 22 June and 12 July 2026 across Nairobi, Kilifi, Isiolo, Kisumu, Vihiga and Bungoma counties and with national-level stakeholders. The Lead Evaluator led data collection, supported by a research assistant, using standardized tools aligned with the evaluation matrix. Documents reviewed included project design, implementation, monitoring and reporting records; relevant UN Women and OHCHR documents; partner reports; and national and county legal and policy frameworks.

Stakeholder mapping was undertaken during inception using the project results framework, implementation arrangements, partner information and consultations with UN Women and OHCHR. Purposive sampling identified stakeholders according to their roles in project design, implementation and oversight; justice and service delivery; coordination and accountability; community engagement; or direct experience of project-supported interventions. The sample sought representation across all six project counties and the national level and included UN entities, the donor, implementing and technical partners, national and county institutions, Judiciary/IAWJ, police, prosecutors, health providers, WROs, HRDs, community actors and survivors. Persons with disabilities and other groups facing intersecting barriers were also included.

The qualitative component reached 176 unique participants across the six project counties and at the national level. Of these, 42 participated in KIIs and 141 in FGDs, with some participants contributing through both methods. The KAP survey reached an additional 183 consenting respondents, comprising 112 project participants and 71 non-participants. Consistent with the inception design, participants were selected purposively to ensure coverage of the six counties, the national level, and the principal stakeholder categories rather than to achieve a statistically representative sample. Accordingly, the table below presents the planned dimensions of coverage alongside the sample achieved.

Table 5: Planned coverage and achieved consultation profile[1]

Dimension	Planned coverage	Achieved coverage
Geography	Six project counties plus national-level stakeholders	176 unique qualitative participants: Nairobi 41; Kilifi 39; Isiolo 25; Kisumu 24; Vihiga 23; Bungoma 18; National 6
Qualitative methods	KIIs and FGDs across principal stakeholder groups	42 KII participants and 141 FGD participants. Eight participants contributed through both methods. Thirteen FGD sessions were conducted: three in Nairobi and two in each of Kilifi, Kisumu, Bungoma, Vihiga and Isiolo.
KAP survey	Project participants and non-participants	183 consenting respondents: 112 project participants and 71 non-participants
Sex/gender	Diverse participation, with emphasis on women and rights holders	136 female; 38 male; 1 gender non-conforming participant; 1 trans man among the 176 qualitative participants
Disability	Include persons with disabilities and disability-related perspectives	4 qualitative participants recorded as persons with disabilities; 13 KAP respondents self-identified as persons with disabilities
Stakeholder categories	UN entities, donor, government, justice and service actors, implementing and technical partners, WROs, HRDs, community actors and survivors	All principal stakeholder categories were represented, including survivors, HRDs, duty bearers, UN/project actors, implementing and technical partners and the donor.

The planned sample established during inception and the achieved consultation profile, including distribution by county, stakeholder category and available demographic characteristics, are provided in the annexes. Some intended stakeholders and remote populations could not be reached. These gaps were considered during analysis and mitigated through consultation with multiple stakeholder categories across all six counties, national-level interviews and triangulation across methods and evidence sources.

Disability inclusion informed participant selection, data collection and analysis. Persons with disabilities participated in qualitative consultations, and 13 KAP respondents identified as persons with disabilities. The evaluation considered accessibility and communication needs and examined disability-related barriers to information, services, justice and participation. Where available, the evaluation analyzed disability-disaggregated KAP and qualitative evidence, alongside evidence from disability-related actors.

4.3 Data analysis, triangulation and quality assurance

KII and FGD data were coded and analyzed thematically in Microsoft Excel against the evaluation questions, OECD-DAC criteria and reconstructed Theory of Change. The analysis examined recurring themes, differences across counties and stakeholder groups, enabling and constraining factors, unintended changes, and divergent perspectives. Contradictory evidence was compared across stakeholder groups, counties and data sources, and findings were qualified where the available evidence remained inconclusive.

[1] KII and FGD participant counts are not additive because eight participants contributed through both methods. The qualitative sample comprised 176 unique participants. Sex/gender and disability figures are reported in aggregate to protect participant confidentiality. The KAP sample comprises 183 respondents who provided consent for participation.

KAP data were cleaned, coded and analyzed descriptively in Excel using frequencies and percentages, with comparisons between project participants and non-participants where relevant. Results-framework data were assessed against targets and reported achievements. Findings were triangulated across documents, monitoring data, KIIs, FGDs and the KAP survey. Greater confidence was placed on findings supported by multiple sources or methods, while findings based on partial, perception-based or conflicting evidence were appropriately qualified.

Quality assurance included standardized tools linked to the evaluation matrix, review of emerging evidence during fieldwork, data cleaning, and cross-checking reported results against available project and partner records. The draft report and recommendations were subsequently reviewed by members of the Evaluation Reference Group, the donor, UN Women and OHCHR, and were also assessed against GERAAS requirements. The evaluator considered these comments alongside the underlying evidence and revised the report where they improved factual accuracy, analytical clarity, evidentiary support, internal consistency or alignment with evaluation standards, while retaining independent evaluative judgment. The resulting revisions strengthened triangulation, clarified limitations and areas of divergent evidence, and improved the traceability of findings, conclusions and recommendations.

4.4 Ethical and survivor-centered safeguards

Participation was voluntary and based on informed consent. Participants were informed of the evaluation purpose, confidentiality arrangements, their right to decline questions or withdraw, and how the information would be used. Names and other identifying information were excluded from analysis and reporting, and transcripts and participant records were anonymized. Consultations were conducted in settings that protected privacy and confidentiality, with language and interpretation needs accommodated where required. Evaluation records were handled as confidential evaluation data. This evaluation report does not publish names of survivors or link quotations to personally identifying details.

Survivor consultations followed do-no-harm and trauma-informed principles. Data collectors were briefed on survivor-centered interviewing, confidentiality, safeguarding and managing distress. Discussions focused on service access, responsiveness, dignity, safety, justice, economic empowerment and perceived change rather than requiring detailed accounts of violence. Participants controlled the extent of information they shared, and interviews could be paused or discontinued where necessary. Where protection, psychosocial or other support needs arose, existing referral mechanisms and service providers were used rather than attempting to provide support through the evaluation itself.

Gender equality, human rights and inclusion informed participant selection, data collection and analysis. Particular attention was given to disability, age, geography and other forms of marginalization. Accessibility needs were accommodated where feasible. Children were not directly interviewed as GBV survivors; consultations concerning children drew on adult stakeholders and service providers. The cleaned qualitative participant record confirms representation of persons with disabilities, while the KAP survey included 13 respondents who self-identified as persons with disabilities. The available records do not consistently identify disability type or the specific reasonable accommodation provided to each participant; this is reported as a documentation limitation rather than reconstructed retrospectively. Disability-related evidence was also obtained from service providers and actors working on accessibility and inclusion.

4.5 Limitations

The purposive, non-probability sampling used for KIIs, FGDs and the KAP survey limits statistical generalization. Participants also differed in their level of project exposure, while some remote populations were harder to reach. Self-reported evidence may have been affected by selection, recall and social-desirability bias. These limitations were mitigated by covering all six counties, including diverse stakeholder groups, triangulating across methods, and qualifying findings based primarily on participant perceptions. KAP findings were treated as indicative.

Gaps in the results matrix, including missing values, limited disaggregation and unclear aggregation, constrained measurement of some results and, in some cases, identification of unique beneficiaries. Available figures were cross-checked against project and partner reports and qualitative evidence and qualified where necessary. Demographic information was also incomplete for some qualitative participants, limiting full disaggregation of the sample achieved.

Finally, wider reforms, programmes and contextual developments also influenced GBV prevention, services and access to justice. The evaluation therefore assessed contribution rather than direct attribution. As data collection occurred around project completion, longer-term institutional, accountability, livelihood and social-norm changes could not yet be fully assessed. Impact and sustainability findings therefore focus on emerging changes and prospects for durability.

5. Findings

The findings are organized around the evaluation criteria of relevance, coherence, effectiveness, efficiency, sustainability, gender equality and human rights, and impact. Each criterion begins with an overall evaluative finding, followed by analysis of the corresponding evaluation questions and supporting evidence from project data, the KAP survey, KIIs, FGDs and document review. The section is organized around a detailed question-and-sub-question structure to provide an explicit response to each evaluation question. To reduce repetition, the summary finding at the start of each criterion and question provides the evaluative judgment, while the subsequent text presents the evidence, analysis and interpretation.

5.1 Relevance

Summary finding: The project was highly relevant to Kenya's GBV prevention, justice and essential-service context. It addressed legal, political, institutional, social, economic and geographic barriers and responded to priorities expressed by survivors and duty bearers. Its ability to reach some remote communities and justice actors was constrained by the extensive geographic coverage of the six counties. Gaps also remained in addressing intersecting vulnerabilities, while the Theory of Change gave limited attention to setbacks, recurrent financing, and the full survivor-centered recovery pathway.

5.1.1 To what extent was the project design and Theory of Change responsive to systemic barriers affecting GBV prevention, access to justice, and access to essential services at national and county levels?

Key Summary finding: The project design and Theory of Change were substantially responsive to the principal barriers affecting GBV prevention, access to justice, and access to essential services. The design addressed interconnected legal, institutional, service-delivery, social, economic and geographic barriers through partnerships with national institutions, county actors, communities and survivors. The longer three-year period and expansion from four to six counties improved the project's fit with the problem's scale and diversity. The evaluation also identified design limitations. Geographic reach varied within all six counties, with interventions generally more visible around established institutional and service points and less consistently reaching more remote communities and actors; these constraints were particularly pronounced in geographically dispersed settings such as Isiolo and Kilifi. Several pathways also depended on under-resourced public services, while the Theory of Change assumed a more orderly progression from awareness to reporting, services and justice than survivors commonly experienced. Overall, the strategic logic was credible and contextually grounded, but depended heavily on local institutional capacity, financing, staff continuity and specialized services[2].

5.1.1.1 What key systemic barriers affecting GBV prevention, access to justice, and essential services were targeted by the project?

Summary finding. The project targeted the main barriers across the prevention, reporting, service, and justice chain. Its broad scope matched the interconnected nature of GBV, while limited resources limited the depth of coverage across institutions, localities, and survivor groups.

The project targeted barriers across the full prevention and response system. At the legal and policy level, it addressed uneven implementation of GBV laws, policies, institutional guidance, and county plans. At the institutional level, it focused on gaps in the knowledge and practice of police officers, prosecutors, judicial officers, health personnel, county officials, and human rights defenders. It also addressed weak coordination among actors, fragmented referral arrangements, limited institutional accountability, and gaps in GBV data and evidence systems. These priorities were consistent with the diagnosis that informed the earlier phases, which identified weak duty-bearer capacity, inadequate cross-sectoral coordination, and incomplete GBV data as central constraints[3].

The field evidence confirmed that these barriers remained material during the phase under evaluation. Justice-sector respondents described incomplete or poorly prepared medical and police documentation, inconsistent preservation of evidence, case backlogs, witness interference, informal settlement of sexual offenses, and staff transfer that weakened continuity. Police and health respondents raised shortages of trained personnel, private interview rooms, transport, equipment, and resources for case follow-up. County departments and civil society actors reported inadequate funding for coordination structures and limited integration of institutional data. The donor's assessment similarly identified financial

[2] Triangulation of the project results framework and Theory of Change, the earlier project evaluation, the KAP survey, and KIIs and FGDs conducted across the six counties, June to July 2026.

[3] [3]Final Evaluation Report of the Let It Not Happen Again Project, covering the 2019 to 2023 phases, 2024, pp. 25–27.

barriers, women's economic dependence, limited legal awareness, discriminatory social norms, weak justice-sector implementation, low public confidence, unequal geographic access, and weak coordination and evidence systems[4].

The project also targeted barriers experienced directly by survivors and women at risk. These included low awareness of rights and referral pathways, stigma, fear of retaliation, family pressure, economic dependence, transport costs, long distances, limited legal aid, inadequate psychosocial support, and the shortage of shelters and safe accommodation. Survivors in Bungoma described the combined effects of poverty, remote settlements, poor roads, delayed court proceedings, informal family settlements, and threats to witnesses. In Isiolo, distance, poor transport, limited livelihood options, and restrictive social norms shaped whether survivors could reach a service provider or continue with a case. In Nairobi's informal settlements, respondents emphasized local power relations, the role of informal dispute handlers, limited survivor support after arrest, and the economic consequences of violence.[5]

The intervention package corresponded closely with this diagnosis. Policy and institutional support addressed legal and administrative barriers. Training and mentoring addressed knowledge and practice gaps. Court User Committees, gender technical working groups, and referral networks addressed coordination. Community dialogues and legal literacy addressed awareness, stigma, and reporting. Legal aid, psychosocial support, accompaniment, and referrals addressed immediate survivor needs. Financial literacy, vocational skills, and livelihood support addressed economic vulnerability among selected women. The design therefore recognized that access to justice depended on several connected institutions and forms of support.

An OHCHR respondent explained why the project moved beyond county-level training:

> *"When you go farther to the sub-county and ward level, you realize that communities are not very aware. GBV is not something that people talk about freely, and families often shy away from reporting defilement. We therefore had to invest heavily in community dialogues."*[6]

Two qualifications are important. First, the project could influence institutional practice, relationships, survivor support, and barriers such as stigma, limited awareness, and under-reporting, while public financing, staffing, infrastructure, and court workloads remained largely outside its direct control. Second, the breadth of barriers created a wide intervention portfolio, spanning institutional capacity, coordination, service access, social norms, economic vulnerability and geographic access. Available resources could not provide the same level of support across all institutions, localities and survivor groups. These constraints affected the scale of response more than the relevance of the barriers identified.

5.1.1.2 To what extent were project design and Theory of Change responsive to national and county contexts?

Summary finding. The design was closely aligned with national mandates and enabled meaningful county-level adaptation. Responsiveness was uneven within counties, especially in remote wards and sub-counties where services, transport, and partner presence were limited.

At the national level, the design reflected Kenya's policy and institutional arrangements for GBV prevention and access to justice. It engaged institutions responsible for policy coordination, investigation, prosecution, adjudication, health care, oversight, human rights protection, and survivor assistance. Work with the Judiciary, National Police Service, Office of the Director of Public Prosecutions, Independent Policing Oversight Authority, national human rights institution, and the State Department responsible for gender, in accordance with their formal mandates. The project also maintained the accountability strand developed in earlier phases, including technical and victim-support work connected to serious violations arising from electoral violence[7].

The geographic design combined continuity with expansion. Nairobi, Kisumu, Bungoma, and Vihiga allowed the project to build on trust-building between right-holders and duty-bearers, and coordination structures established during the first three phases. Adding Kilifi and Isiolo extended implementation to coastal and arid and semi-arid contexts. This was a relevant choice because the two counties presented different combinations of geographic isolation, institutional reach, livelihood insecurity, social norms, and service availability that the duty-bearers at the national level were cognizant of and,

[4] KII with donor representative, AICS, 20 July 2026; KIIs and FGDs with justice-sector actors, county officials, health providers, HRDs, and service providers across the six project counties, June to July 2026.
[5] FGD with survivors, Bungoma and Mt Elgon, 1 July 2026; KII with county GBV health focal person, Isiolo, June 2026; KII with community HRD, Kibera, Nairobi, June to July 2026.
[6] KII with OHCHR project personnel, July 2026
[7] End Project Results Matrix; Final Evaluation Report of the earlier Let It Not Happen Again phases, 2024, pp. 25–27 and 33–37.

based on that, called for expansion in these two counties. The project period also coincided with increased national concern about femicide and technology-facilitated GBV, issues identified in the Mid-Term Review of the UN Women Kenya Strategic Note[8].

County evidence shows that the same national framework operated through different local realities. Kilifi respondents identified key challenges including defilement, intimate-partner violence, long distances to services, limited police and court coverage in remote sub-counties, inadequate shelter facilities, and gaps in evidence collection and management. Isiolo respondents emphasized dispersed settlements, pastoral livelihoods, restrictive social norms, limited reporting, and weak service reach beyond Isiolo town. Bungoma respondents described the isolation of Mt Elgon sub-county, poor roads, poverty, incest, and family settlement of cases. Nairobi had a denser service network, together with marked differences across informal settlements and police stations. Kisumu and Vihiga had more established justice and coordination structures, although respondents continued to report case delays, witness interference, and limited child-sensitive and post-judgment support as challenges.[9]

The design allowed some adaptation to these differences through local partners, county structures, community champions, Court User Committee subcommittees, community dialogues, and referral networks. An OHCHR respondent summarized the operating principle:

> *"Strategies that work in one county will not necessarily work in another. It takes listening to beneficiaries and to the duty bearers they engage with so that responses can be tailored to what works for them."*[10]

This contextual responsiveness was clearest where implementing partners and county actors used existing local relationships to determine whom to train, where to conduct dialogues, and how to link community actors with service providers. In Kibera, for example, a community respondent reported that the intervention followed a local assessment that identified capacity gaps among police and women human rights defenders, as well as weaknesses in referral relationships. In Isiolo, the project worked through health focal persons, community health structures, chiefs, religious leaders, and county coordination mechanisms. In Kilifi, engagement with health providers, police and Court User Committees supported multi-agency case follow-up across a county where long distances between communities and service providers presented significant access challenges[11].

Responsiveness within counties varied. Respondents distinguished county headquarters and accessible sub-counties from wards and villages farther from police stations, hospitals, courts and partner offices. Remote parts of Bungoma (Mt. Elgon), Kilifi (Ganze and Bamba) and Isiolo remained particularly difficult to reach. The six-county selection was contextually appropriate, although coverage depth varied within counties. The project also demonstrated adaptability to emerging forms and changing patterns of GBV. Technology-facilitated violence was incorporated into judicial capacity development, while the growing concern around femicide informed national-level engagement and dialogue during implementation, despite neither issue being a distinct intervention pathway in the original design.

5.1.1.3 Were the intervention pathways and assumptions realistic and contextually appropriate?

Summary finding. The intervention pathways were plausible and contextually grounded. Several assumptions were overly optimistic regarding institutional resources, staff continuity, survivor safety, household pressure, and the orderly movement from awareness to justice and recovery.

The Theory of Change rested on two related pathways. The first linked stronger laws, institutional capacity, monitoring, accountability, and coordination with more effective GBV prevention and response systems. The second linked awareness, legal awareness, referral pathways, survivor-centered services, psychosocial support, and economic empowerment with women's ability to seek support, pursue justice, and reduce their exposure to further violence. These pathways were

[8] County KIIs and FGDs conducted in Nairobi, Kisumu, Bungoma, Vihiga, Kilifi, and Isiolo, June to July 2026.
[9] KII with OHCHR project personnel, July 2026.
[10] KII with OHCHR project personnel, July 2026
[11] KII with community HRD, Kibera, Nairobi; KII with county GBV health focal person, Isiolo; KIIs and FGDs with health, police, judicial, county, and civil society actors in Kilifi, June to July 2026.

plausible because survivors commonly move across several institutions and may require medical care, police assistance, legal advice, counseling, shelter, transport, protection, and livelihood support at different stages.[12]

The shift from annual phases to a three-year project provided a more practical and achievable implementation timeframe. Institutional reforms, changes in practices related to survivor handling, referrals, evidence management and case processing, psychosocial recovery, and shifts in social norms require repeated engagement. Both implementing partners and the donor respondent connected the longer period and larger grant to lessons from the earlier phases. An OHCHR respondent stated:

> *"Achieving this Theory of Change takes time. We know how long it takes to change attitudes and behaviours. It does not happen overnight, and the three-year project took account of that."*[13]

Several assumptions underpinning the Theory of Change did not consistently hold in practice. The institutional pathway assumed that capacity strengthening of personnel would remain in place, coordination structures would be financed, and institutions would have staff, transport, private facilities, and equipment to apply new knowledge. Transfers and rotations repeatedly disrupted teams whose capacities had been strengthened. County budgets did not consistently finance meetings, shelters, transport, or survivor support. The service pathway assumed that greater awareness and reporting would be met by accessible legal aid, psychosocial care, protection, shelter, and case accompaniment. In several counties, demand exceeded the available services. The pathway from reporting to access to justice was also affected by family settlements, threats, incomplete evidence, adjournments, and the cost of repeated travel.

A county gender official in Kilifi questioned the linear form of the design:

> *"Our projects operate in a more linear than cyclical way. They assume that after one, two will follow, and then three. With GBV, you may be implementing at stage three and find that you have gone back to zero or one".*[14]

This observation is consistent with survivor accounts. A woman may know where to report but still be unable to afford transport. A case may reach court and later be withdrawn after threats or family pressure. A survivor may receive short-term shelter and then return to the same economic circumstances. These patterns indicate that feedback loops, repeated support, and recognition of setbacks should have been more explicitly articulated in the Theory of Change.

The results framework architecture created an additional design limitation. Several indicators measured counts of policies, trainings, mechanisms, and service users, while fewer indicators captured continuity of survivor support, quality of institutional practice, accessibility across locations and groups, or movement through the full justice pathway. The donor reported difficulty in tracing progress against some indicators and distinguishing visible field-level changes from the incomplete data in annual reporting. A more explicit contribution framework, supported by pathway-level indicators and routine disaggregation, would have made the Theory of Change easier to test and adapt[15].

5.1.2 How well did the project respond to the needs and priorities of women and girls, particularly GBV survivors and those facing intersecting vulnerabilities?

Summary finding. The project responded substantially to the needs expressed by women and girls who participated in the evaluation, particularly the need for information, psychosocial support, referrals, legal accompaniment, institutional responsiveness, and economic skills. Survey respondents reported improved knowledge of services and referral pathways, while survivors and community accounts described greater confidence in seeking help and navigating institutions. Responsiveness was less consistent for women and girls in remote areas, persons with disabilities, adolescents, street-connected populations, and survivors requiring safe accommodation, sustained legal aid, transport, or post-judgment support. Accessibility therefore depended on location, the presence of an active partner or human rights defender, and the availability of services beyond those directly financed by the project. The evidence supports a positive assessment among those reached, alongside clear limits in coverage, continuity, and inclusion.

[12] Project Theory of Change and results framework as reflected in the End Project Results Matrix; KIIs with UN Women, OHCHR, implementing partners, and county actors, June to July 2026.
[13] KII with OHCHR project personnel, July 2026.
[14] KII with donor representative, AICS, 20 July 2026; End Project Results Matrix
[15] KII with donor representative, AICS, 20 July 2026

5.1.2.1 To what extent did project interventions respond to the needs and priorities of survivors and women at risk?

Summary finding. Interventions responded well to needs for information, counseling, accompaniment, referral, health care, legal support, and economic skills. However, access was uneven for survivors facing additional barriers, including persons with disabilities and those living in remote areas. Shelter, transport, sustained legal aid, post-judgment support, service accessibility, and longer-term economic recovery remained important gaps.

Women and girls consulted during the evaluation identified counseling, legal information, accompaniment, referrals, medical support, safe accommodation, transport, protection, and economic support as central needs. Project-supported partners provided several of these services directly and connected survivors to police, health facilities, courts, legal aid, shelters, and psychosocial providers. The end-project results matrix records 4,059 women and girls accessing essential services against a target of 1,800.[16]

Psychosocial support was among the interventions most consistently valued by survivors. Participants connected counseling and peer support with the ability to speak about their experiences, resume daily activities, and support other women. A survivor in Bungoma explained:

> *"Before the support, I could not open up about what had happened. I would cry the whole day without saying anything. The support enabled us to accept ourselves and continue with life."*[17]

Legal accompaniment and referrals also responded to practical difficulties in moving between institutions. Human rights defenders and community actors described escorting survivors to health facilities and police stations, following cases in court, contacting service providers, and explaining procedures. Police and health personnel reported using project-supported relationships to obtain counseling, shelter referrals, legal assistance, and transport support. These links were particularly useful for survivors with limited knowledge of the system or who feared approaching formal institutions.[18]

The inclusion of financial literacy, vocational skills, livelihood grants, and start-up support addressed the economic dependence repeatedly identified by survivors, implementing partners, and the donor. The results matrix records 364 women gaining financial or vocational knowledge against a target of 300. Qualitative accounts indicate that some beneficiaries used the support to establish small businesses or strengthen their ability to meet household needs. The available evidence is stronger on training and initial support than on changes in income, business survival, or reduced exposure to violence.

Important needs nevertheless remained insufficiently addressed. Respondents reported limited access to safe shelters, either because shelters were unavailable in some locations or because existing facilities (most privately owned) lacked sufficient capacity. Other gaps included limited legal aid, transport costs that constrained access to services, inadequate witness protection, short periods of psychosocial support, and limited follow-up after court decisions. Survivors expressed a need for longer-term counseling, more reliable case accompaniment, better-sequenced livelihood support, and continued mentoring after training. A judicial officer in Kisumu described the unresolved issue after judgment:

> *"We need to look at the aftermath. Safe houses may serve during the case, but what happens after that? Do survivors need a place where they can stay, receive training, and begin life again?"*[19]

Access for persons with disabilities remained unequal. The project incorporated some measures intended to improve accessibility, including sign-language interpretation in selected activities and engagement with disability-related actors. However, the evaluation found that persons with disabilities continued to encounter physical, communication and attitudinal barriers when accessing GBV information and services. These barriers were particularly significant where services were physically inaccessible, information was not available in appropriate formats, or service providers lacked the capacity to respond to different accessibility needs. The evidence therefore suggests that disability inclusion was recognized within implementation, but accessibility measures were not sufficiently systematic across the survivor support pathway.

The project therefore responded to a broad set of survivor priorities and introduced a more holistic package than the earlier election-focused phases. The extent of response nevertheless varied by service and among different groups of survivors.

[16]End Project Results Matrix, indicator 2.1A.
[17]FGD with survivors, Bungoma and Mt Elgon, 1 July 2026.
[18]KIIs with HRDs, police gender officers, health providers, and implementing-partner personnel in Nairobi, Bungoma, Kilifi, and Isiolo, June to July 2026.
[19]KII with judicial officer, Kisumu, July 2026.

Awareness, referral, psychosocial support, and capacity development were more consistently visible across the evidence. Shelter, continuous legal support, transport, protection, and longer-term recovery remained less available and often depended on external providers or short-term partner resources. Persons with disabilities faced additional physical, communication, and attitudinal barriers to accessing support. While the project introduced some accessibility measures, these were not consistently available across services and locations.

5.1.2.2 How effectively were intersecting vulnerabilities considered in project implementation?

Summary finding. Intersecting vulnerabilities were recognized in the design and addressed in selected activities. Coverage, accessibility standards, disaggregated monitoring, and representation of persons with disabilities and other marginalized groups remained uneven.

The project design recognized that survivors were not a uniform group. It referred to women and girls facing exclusion related to disability, age, poverty, and geographic location. Implementation included some targeted engagement with persons with disabilities, young women, rural communities, informal-settlement residents, older women, and sexual and gender minorities. Some activities provided sign-language interpretation, and partners used community champions and local networks to reach women who might not approach formal institutions independently.

A UN Women respondent described the intended approach:

> *"A survivor could be an older woman or a person with a disability. The approach was to look at the survivor in her entirety."*[20]

Evidence from implementation shows partial achievement of this intention. The KAP survey included 13 respondents who identified as persons with disabilities. Some service providers reported access to sign-language interpretation and referral contacts for shelters serving persons with disabilities. Respondents also described engagement with adolescents, widows, teen mothers, remote pastoral communities, and women living in informal settlements. These examples show that selected activities and partnerships considered intersecting vulnerabilities.

Coverage was uneven. Fifty-seven (57) per cent of KAP respondents agreed that persons with disabilities and marginalized groups continue to face barriers in accessing services. Duty bearers reported inaccessible buildings, limited sign-language capacity, communication barriers, stigma, and limited knowledge of rights. A Nairobi service provider stated that persons with disabilities were "not fully engaged" during much of the project and that stronger organizational attention emerged close to project completion. The same respondent identified adolescent girls, teen mothers, and street-connected children as underserved.[21]

County evidence identified other groups with limited reach. A Kilifi health respondent reported that disability inclusion had not been sufficiently visible and recommended deliberate engagement with organizations of persons with disabilities. OHCHR personnel described difficulty identifying partners working with LGBTQ communities in Isiolo. Respondents also identified girls in remote schools, older women caring for affected children, women living far from county headquarters, and remote pastoral communities. Some duty bearers called for greater engagement with men and boys, boda boda operators, elders, religious leaders, and education institutions because of their influence over prevention, reporting, and survivor support.[22]

These findings suggest that inclusion was present as a design principle and in selected practices, while implementation relied mainly on broad community targeting and the reach of existing partners. A stronger inclusion strategy would have specified target groups, accessibility standards, partner responsibilities, reasonable accommodations, disaggregated indicators, and dedicated resources to reach remote and marginalized populations.

5.1.2.3 Did women and girls perceive services and interventions as accessible and responsive?

Summary finding. Women and girls reached by the project generally perceived interventions as useful and responsive. Accessibility depended on location, transport, service capacity, privacy, and the presence of an active HRD, partner, or institutional focal person.

[20]KII with UN Women project personnel, July 2026. .
[21]KAP survey, n=183 consenting respondents; KII with implementing-partner psychosocial service provider, Nairobi, June to July 2026.
[22]KIIs with Kilifi health provider and OHCHR project personnel; KIIs and FGDs with county and community actors across the six project counties, June to July 2026.

The KAP survey presents a positive assessment among respondents reached by or familiar with the project. 90% reported improved awareness of available GBV services. A further 93.9 percent reported improved knowledge of how and where to report, and the same proportion reported improved awareness of referral pathways. 85.5 percent stated that they knew where to refer a person experiencing GBV, while 77.5 percent agreed that access to justice and essential services had improved.[23]

Perceptions were more positive among project participants than among non-participants. Improved awareness of GBV rights was reported by 95.5 percent of project participants and 75.7 percent of non-participants. Participants also reported more positive views concerning institutional response, community change, and the likelihood that gains would continue. These differences are consistent with project exposure, although the non-probability survey design does not establish causation and differences in respondent composition may also have influenced the results.[24]

The survey also showed a gap between knowledge of services and the reported availability of specialized support. Police and health services were identified as available by about 69% and 70% of respondents, respectively. Psychosocial support was identified by about 55 percent, legal aid by about 50 percent, and shelters or safe spaces by 31 percent. The results matrix reports service satisfaction of 70.3 percent against a target of 70 percent, but the annual sample sizes and calculation method require verification. The KAP questionnaire used a different measure and cannot directly verify the reported service-satisfaction result.[25]

Qualitative accounts support this mixed picture. Survivors and community actors described more respectful counselling, greater privacy in some facilities, clearer referral pathways, useful accompaniment, and increased confidence in seeking help. A Bungoma participant explained that the project helped communities understand the sequence of seeking medical care, reporting to police, preserving evidence, and following the case through court. Another survivor described the limit of that reach:

> *"Many people know the referral pathways, but those living in the interior and on top of the mountain did not all receive the information. Awareness has increased, especially among those who benefited from the project."*[26]

Accessibility was strongest where an active human rights defender, a women's rights organization, a health focal person, a police gender officer, or a community champion maintained direct links with other service providers. It was weaker where survivors had to travel long distances, pay for repeated transport, or find legal aid and shelter independently. An Isiolo health respondent described distances of several hundred kilometers over rough roads as a major deterrent to seeking justice. A community HRD in Isiolo identified transport as the single largest operational barrier to accompanying survivors and following cases.[27]

Service quality also varied. Some respondents reported that their privacy was maintained and that they received supportive treatment from police and health providers. Others reported repeated questioning, inadequate privacy, communication barriers, court delays, and pressure to withdraw cases. A Kilifi police officer noted that the gender desk lacked a child-friendly private space and basic equipment. These findings show that many women and girls perceived the project-supported interventions as useful and responsive, while their overall experience remained shaped by the capacity and conduct of the wider service system.[28]

5.2 Coherence

Summary finding. The project was substantially coherent with UN Women's strategic priorities, OHCHR's human rights mandate, the UNSDCF, and Kenya's GBV and justice frameworks. The joint arrangement combined complementary mandates and used existing public and civil society structures. Coherence was strongest in institutional partnerships and referral coordination. Integrated data, reliable financing of coordination mechanisms, links with education institutions, and connections between immediate response and longer-term recovery were less developed.

[23] KAP survey, n=183 consenting respondents, analysis conducted August 2026.
[24] KAP survey, n=183. Project participants, n=112; non-participants, n=71.
[25] KAP survey, n=183; End Project Results Matrix, indicator 2.1B.
[26] FGD with survivors, Bungoma and Mt Elgon, 1 July 2026.
[27] KII with county GBV health focal person, Isiolo; KII with community HRD, Isiolo, June 2026.
[28] KII with police gender desk officer, Kilifi, 22 June 2026; survivor and duty-bearer KIIs and FGDs across the six counties, June to July 2026.

5.2.1 To what extent was the project coherent with the UN Women Kenya Strategic Note 2023–2026 and aligned with UN Women's normative, operational, and coordination mandates?

Summary finding. The project was closely aligned with Outcome 2 of the UN Women Kenya Country Office Strategic Note and with UN Women's three-part mandate. It was also aligned with the UN Sustainable Development Cooperation Framework (UNSDCF) Strategic Priority 1: People and Peace, particularly its emphasis on GBV prevention and response, survivor-centered access to justice and essential services, strengthened institutional accountability, and coordinated protection systems. The project translated these priorities into an integrated approach combining policy and institutional reform, service delivery, community engagement, coordination, and women's economic agency. Complementarity with the wider UN Women portfolio was visible through shared institutions and partners, although stronger portfolio-level mapping and clearer attribution of partner contributions would have further strengthened coherence. Further, the project was aligned with OHCHR Country strategy and Annual Workplans, strengthening OHCHR's support for grassroots human rights networks to advance access to justice for survivors of GBV and capacity building of duty bearers on survivor-centered approaches to GBV prevention and response. It also advanced third and fourth cycle recommendations from the Universal Periodic Review 2025 and the Convention on the Elimination of All Forms of Discrimination Against Women by engaging women's groups, strengthening gender-based violence referral pathways, expanding survivor support, improving early warning systems, embedding prevention into electoral preparedness, and promoting accountability for gender-based violence

5.2.1.1 To what extent was the project aligned with the priorities of the UN Women Kenya Strategic Note 2023–2026?

Summary finding. Alignment was strong. The project directly supported the Strategic Note priority on freedom from violence and access to quality essential services, as well as related priorities on women's agency, accountable institutions, and coordination.

The project's interventions in laws and policies, capacity development for justice actors, accountability, survivor-centered services, financial and vocational skills, and coordination aligned with Outcome 2 of the UN Women Kenya Strategic Note 2023-2026. It also supported the UNSDCF priorities on human rights, gender equality, access to justice, and inclusive protection services.

The design also responded to issues identified in the Strategic Note Mid-Term Review. These included femicide, technology-facilitated GBV, uneven service availability, and weak coordination. Judicial training addressed technology-facilitated violence, while policy work, survivor services, and community engagement supported the wider response to violence against women and girls. The project's three-year period, psychosocial component, economic empowerment activities, and expansion to Kilifi and Isiolo reflected lessons from the earlier phases.[29]

5.2.1.2 How effectively did the project contribute to UN Women's normative, operational, and coordination mandates?

Summary finding. The project contributed to all three mandates. Its strongest contribution was the combination of operational delivery and coordination. Progress on policy results was material, with several planned frameworks and analytical products still incomplete.

The normative contribution covered policy development, review, dissemination, budget advocacy, and institutional guidance. The results matrix records eight laws, policies, strategies, or plans developed or reviewed against a target of 11, and eight legal or policy frameworks implemented against a target of 10, and five petitions or budget memoranda against a target of 11. These results show substantive progress, with an implementation gap remaining.

The operational contribution included capacity development, community awareness, survivor referrals, legal and psychosocial services, and women's financial and vocational skills. The coordination contribution brought together national and county institutions, KNCHR, NGEC, UN entities, the donor, implementing partners, women's rights organizations, HRDs,

[29]UN Women Kenya Country Office, Mid-Term Review of the Strategic Note 2023–2026, 2024, pp. 14–16 and 23–24; Final Evaluation Report of the earlier Let It Not Happen Again phases, 2024.

and survivor networks. The reported 27 coordination mechanisms and 62.3 percent participation of women indicate substantial activity.[30]

5.2.1.3 Did the project complement other UN Women initiatives on GBV prevention, gender equality, and access to justice?

Summary finding. The project complemented a wider UN Women Kenya portfolio addressing GBV prevention and response, women's political participation, technology-facilitated GBV, legal reform, access to justice, and women's economic empowerment. Complementarity was evident in the way different initiatives addressed related legal, institutional, social, political, digital, and economic dimensions of violence against women and girls. Shared institutions, county platforms, partners and target groups created further opportunities for interaction. These complementarities were not systematically mapped in project reporting, making it difficult to assess their full contribution or identify potential combined effects that were missed.

The project operated within a broader UN Women portfolio rather than as a stand-alone GBV intervention. Its focus on survivor-centered access to justice, essential services, institutional capacity and referral systems complemented the Canada-funded program on women's political participation, which addressed violence against women in politics through engagement with justice and security actors, women's rights organizations and institutional responses to physical and technology-facilitated political violence. This extended GBV prevention and response into political and electoral spaces where women leaders, aspirants and public figures face particular risks.

Complementarity was also evident with DigiKen, which generated evidence and policy guidance on technology-facilitated GBV and women's safe participation in digital spaces, and with the Ending Discriminatory Laws and wider rule-of-law portfolio, which addressed gender-responsive legal reform and structural weaknesses in the legal environment affecting women and girls. These initiatives complemented the project's work with survivors and justice institutions by addressing emerging forms of violence and aspects of the wider legal and policy environment within which survivors seek protection and justice.

The economic empowerment component provided another important connection across the portfolio. Financial literacy, vocational training, livelihood support and survivor economic recovery complemented wider UN Women women's economic empowerment initiatives. This linkage recognized the role of economic dependence in shaping survivors' capacity to leave abusive situations, pursue justice and sustain recovery. The project also complemented wider EVAWG and coordination work through engagement with GBV coordination structures, policy processes, state institutions and civil society actors.

> *"The roles were clear, and the various roles were very complementary."*[31]

Taken together, these initiatives addressed different but connected dimensions of GBV prevention and response. The Italy-funded project concentrated particularly on survivor services, referrals, institutional capacity and access to justice; other portfolio interventions addressed violence against women in politics, technology-facilitated GBV, discriminatory laws and economic vulnerability. The main gap was at the level of portfolio documentation and learning. Project reports did not consistently map these connections or demonstrate how results from different initiatives reinforced one another. A portfolio-level map of common institutions, counties, target groups, partners, referral pathways and intended results would have provided stronger evidence of coherence and helped identify opportunities for greater collaboration.

5.2.2 How effectively did the project complement national and county GBV frameworks, justice-sector reforms, and related initiatives to ensure harmonized and coordinated GBV prevention and response?

Summary finding. The project effectively complemented national and county systems by working within their existing mandates and structures. This approach strengthened local ownership and reduced the risk of parallel delivery. Harmonization was most visible in Court User Committees, technical working groups, and referral networks. Financing gaps, separate data systems, variable county implementation, and limited links to schools and longer-term recovery services reduced the depth of coherence.

[30] End Project Results Matrix, coordination and women's participation indicators; KIIs and FGDs with UN Women, OHCHR, county actors, justice institutions, HRDs, and implementing partners, June to July 2026.
[31] KII with UN Women project personnel, July 2026.

5.2.2.1 To what extent was the project aligned with national and county GBV priorities and justice reforms?

Summary finding. Formal alignment was strong and reinforced through engagement with national and county gender sector coordination mechanisms, which helped identify and shape GBV priorities. Practical implementation of these priorities remained varied because policies, plans and institutional mandates were supported by varying levels of financing, staffing, facilities and political commitment.

The project worked within Kenya's legal and institutional framework on GBV and access to justice. It engaged institutions responsible for policy development and implementation, coordination, investigation, prosecution, adjudication, health care, oversight, legal aid and survivor support. County engagement included gender departments, health services, police gender units, prosecutors, courts, Court User Committees, HRDs and women's rights organizations.[32]

Importantly, alignment was also supported through engagement with the National Gender Sector Working Group and gender sector working groups at subnational level. These coordination mechanisms brought together government, UN entities, civil society and other actors around shared gender and GBV priorities and provided an institutional space for identifying gaps, coordinating responses and aligning interventions with emerging priorities. The project's engagement through these structures therefore strengthened alignment with priorities defined collectively within the wider GBV response system, rather than relying solely on alignment with formal policies and plans.

At county level, stakeholders cited support to GBV policies in Kilifi, Kisumu, Bungoma and Vihiga, alongside specialized and child-sensitive justice arrangements, referral pathways and institutional capacity strengthening. Implementation of these frameworks remained uneven. Respondents reported that policies and coordination commitments were not always matched by dedicated budgets, shelters, transport, adequate staffing or accessible services[33]. The evaluation therefore finds strong alignment at the policy and coordination level, with more variable translation of these priorities into adequately resourced services and institutional practice.

5.2.2.2 How effectively did the project complement existing GBV prevention and response initiatives?

Summary finding. Complementarity was substantial. The project worked through existing national and county coordination and service-delivery structures, including Gender Sector Working Groups, and reinforced public and community mechanisms already engaged in GBV prevention and response. It added specialized gender equality, human rights and accountability expertise. Gaps remained in education-sector engagement and in connections between justice processes, shelter, reintegration and longer-term livelihoods.

The project largely worked through and strengthened existing structures rather than establishing parallel mechanisms. These included the National Gender Sector Working Group and subnational Gender Sector Working Groups, Court User Committees, county technical working groups, police gender desks, health facilities, community health structures, HRD networks, women's rights organizations and survivor groups[34]. The Gender Sector Working Groups were particularly important because they provided platforms for coordinating actors, identifying GBV priorities and gaps, and connecting project interventions with the wider prevention and response architecture. At county level, this was complemented by operational mechanisms linking justice, health, gender and community actors.

UN Women and OHCHR brought complementary expertise to these structures and interventions. UN Women contributed gender equality programming, project management, partner coordination, monitoring, survivor services and economic empowerment components. OHCHR contributed integration of human rights standards through legal and policy expertise, capacity building to steer accountability through investigations and prosecution for emblematic cases of sexual violence, and advocacy and technical support to HRDs, investigators, prosecutors, oversight bodies and victim advocates. Through the groundbreaking case of Baby Pendo, OHCHR did not only contribute to strengthening jurisprudence on victim participation in court but also enhanced cooperation between duty-bearers(ODPP, IPOA and KNCHR) with victims' advocates for strengthened victim and witness strategy PJI's engagement was mainly channeled through OHCHR, although the partner identified scope for closer programmatic interaction with UN Women.[35]

Overall, the project complemented existing initiatives by strengthening and connecting structures already operating within the GBV response system and bringing additional technical expertise where gaps existed. Remaining weaknesses concerned

[32] Project documents and KIIs with national and county institutions across the six project counties, June to July 2026.
[33] County KIIs in Kilifi, Isiolo, Kisumu, Bungoma, and Vihiga, June to July 2026; End Project Results Matrix.
[34] KIIs and FGDs with Court User Committee members, police, health providers, county departments, HRDs, and WROs, June to July 2026.
[35] KIIs with UN Women, OHCHR, and Partners for Justice International, June to July 2026.

areas where this wider system itself was less connected, particularly education-sector engagement and links between justice processes and shelter, reintegration, livelihood and longer-term recovery support.

5.2.2.3 Did coordination and referral systems strengthen harmonization and reduce duplication?

Summary finding. Coordination and referral systems improved harmonization and working relationships. Their functionality depended on active focal persons, facilitation of meetings, communication resources, and partner presence. Separate records and irregular meetings remained important constraints.

Police, prosecutors, judicial officers, health workers, county officials, HRDs, and women's rights organizations described more direct communication and clearer referral roles. HRDs gained access to Court User Committees in several counties. This created a channel for community concerns and case follow-up. Specialized subcommittees in Kilifi and Kisumu also focused coordination on GBV and child justice.[36]

> *"We know each other. Communication becomes easier. If you are stuck somewhere, it is just a call."*[37]

Coordination meetings became irregular when facilitation was unavailable. Police, health facilities, courts, county departments, helplines, and civil society organizations continued to keep separate records. The results matrix reports one functioning interoperable GBV data system, through HAK 1195, against a target of three, while county evidence points to continued data silos. This indicates partial progress toward interoperability rather than full achievement across the intended systems.

5.3 Effectiveness

Summary finding. The project was substantially effective, with its strongest results concentrated in survivor support, coordination and referral systems, and selected institutional and justice-sector interventions. Reported achievements were particularly strong in access to essential services, women's participation, specialized justice arrangements, financial and vocational knowledge, justice-actor knowledge, and awareness of reporting and referral pathways. Results were more mixed for policy implementation, budget advocacy, community sensitization, analytical products, and interoperable data systems. Overall, the project achieved greater depth where it worked intensively with survivors, partners and institutional actors, while interventions requiring broader coverage, institutional uptake or systemic change progressed more slowly.

The table below presents the end-project results.[38]

Table 6: Simplified End of Project Results Framework[39]

Indicator (shortened)	End target	Reported result	Assessment
Legal and policy frameworks implemented	10	8	Partially achieved
GBV cases reported	25,041	31,460	Achieved
Average case-disposal time	5	6	Partially achieved
Laws, policies, strategies, and plans developed or reviewed	11	8	Partially achieved
Trained actors reporting increased knowledge	75%	78.3%	Achieved
GBV analytical reports produced	8	5	Partially achieved
Functioning interoperable GBV data system	3	1	Partially achieved
Justice actors with increased knowledge	1,200	1,256	Achieved
Specialized courts, POLICARE centers, and police gender units	10	12	Achieved
Petitions and budget memoranda submitted	11	5	Partially achieved
Women and girls accessing essential services	1,800	4,059	Achieved

[36]KIIs and FGDs with justice and service actors in Kilifi, Kisumu, Bungoma, Vihiga, Nairobi, and Isiolo, June to July 2026.
[37]KII with health service provider, Kilifi, June 2026.
[38]End Project Results Matrix.
[39] The assessment draws on the end-project results matrix provided by UN Women (Appendix 8), which has been retained as received. Minor inconsistencies identified during final quality assurance were addressed, and results were qualified where available data did not allow direct comparison or independent verification.

Women and girls satisfied with service quality	70%	70.3%	Reported achieved
People sensitized on GBV and access to justice	25,000	21,602	Partially achieved
Women gaining financial or vocational knowledge	300	364	Achieved
Multistakeholder coordination mechanisms supported	15	27	Achieved
Women's participation in coordination mechanisms	50%	62.3%	Achieved

5.3.1 To what extent did the project achieve its intended outcomes in strengthening institutional systems, accountability mechanisms, and cross-sectoral coordination for GBV prevention and response?

Summary finding. The project made a substantial contribution to institutional capacity, coordination and selected accountability mechanisms. Evidence was strongest for improved working relationships, practical application of training, referral systems and specialized justice arrangements. KAP findings provide complementary evidence that these changes were visible to people reached by the project, particularly through improved knowledge of reporting and referral pathways and perceived improvements in access to services. The results matrix also shows that the justice-actor knowledge indicator exceeded its target, with 1,256 actors against 1,200. Performance was weaker in interoperable data systems, consistent institutionalization, and the speed and completion of cases.

5.3.1.1 To what extent did the project strengthen institutional capacity, systems, and accountability mechanisms for GBV prevention and response?

Summary finding. Capacity and systems were strengthened among participating institutions, with practical mentoring and multi-agency learning contributing to changes in case handling, referrals and survivor engagement. KAP findings indicate that communities and survivors also perceived improved ability to navigate these systems. Staff transfers, short training cycles and limited integration into institutional curricula reduced continuity and coverage.

The project supported policy processes, training, mentoring, specialized courts, police gender units, data systems and accountability work. The results matrix shows that 78.3 percent of trained actors reported increased knowledge, above the 75 percent target, while 1,256 justice actors reported increased knowledge, against a target of 1,200. OHCHR separately reported intensive case mentoring for approximately 120 investigators and prosecutors. These figures reflect different forms and levels of capacity support.

> *"We accompany them every step along the way, giving feedback as they are doing the work."*[40]

Respondents described practical application of this support in evidence handling, privacy, referrals, child-sensitive procedures, survivor engagement and case preparation. The accountability strand supported investigation, prosecution strategy, victim and witness support, and case mentoring on the Baby Pendo case. Despite the complexity of the case as it seeks to hold police commanders culpable for rape as a crime against humanity, the case has had a deterrent measure and continues to be active in court. [41].

The KAP findings provide a complementary perspective on whether changes in institutional and referral systems were visible to intended beneficiaries. Among the 183 respondents, 90 percent reported improved awareness of available services, 93.9 percent improved knowledge of how and where to report GBV, and 77.5 percent agreed that access to justice and essential services had improved. These perceptions cannot be attributed solely to institutional capacity-building, but they align with qualitative evidence of clearer procedures, stronger referral practices, and increased engagement between communities and service providers.

5.3.1.2 How effective were project-supported coordination and referral mechanisms?

Summary finding. Coordination and referral mechanisms were among the project's strongest results. Results-matrix, KAP and qualitative evidence converge around stronger referral relationships and knowledge of service pathways. Effectiveness

[40] KIIs with Partners in Justice International, July 2026.

[41] KIIs with Partners in Justice International and OHCHR project personnel, June to July 2026; interviews with justice-sector actors across the six counties.

was greatest where coordination structures met regularly and active focal persons connected institutions and communities. Geographic reach, recurrent financing and institutional data sharing remained uneven.

The results matrix reports 27 supported coordination mechanisms against a target of 15 and women's participation of 62.3 percent against a target of 50 percent, although the count of mechanisms may include repeated annual support. Qualitative evidence confirms stronger contact among police, prosecutors, courts, health workers, county officials, HRDs and service organizations[42].

The KAP findings reinforce this assessment from the perspective of respondents reached. Some 93.9 percent reported improved awareness of referral pathways, while 85.5 percent stated that they knew where to refer someone experiencing GBV. These results are particularly relevant to coordination because effective referral depends on people knowing where services are located and how to move between them. They should nevertheless be interpreted as perceived improvements among the surveyed population rather than direct measures of institutional coordination.

Performance varied across locations. Coordination arrangements appeared more established in Kisumu, Vihiga and Bungoma, where the project was able to build on relationships between duty-bearers and right-holders, in addition to structures developed during earlier phases. Kilifi and Isiolo were added during the phase under evaluation and therefore had less time than in remote sub-counties, while Isiolo's large distances contributed to weaker connections between county-level structures and distant communities. Nairobi had comparatively dense provider networks in selected informal settlements.

5.3.1.3 To what extent did justice and oversight institutions improve their responsiveness to GBV cases?

Summary finding. Responsiveness improved in case handling, referrals, evidence practice, privacy and collaboration. KAP findings also indicate positive perceptions of access and willingness to seek support. Case delays, witness withdrawal, staff transfers, weak forensic capacity and informal settlements continued to interrupt justice pathways.

Specialized courts and child-justice arrangements were associated with greater privacy, clearer management of GBV cases and more attention to children. Police, prosecutors, health workers and judicial officers reported stronger understanding of evidence and referral responsibilities. Oversight cooperation among IPOA, ODPP, investigators, victim representatives and technical partners also improved[43].

KAP findings provide complementary evidence of perceived improvements in institutional responsiveness. Overall, 77.5 percent of respondents agreed that access to justice and essential services had improved, while 86.7 percent perceived women and girls as more willing to seek support or report GBV. These findings align with qualitative accounts of improved referrals, survivor handling, and institutional engagement, although they do not provide a direct measure of justice-sector performance.

The results matrix records 31,460 reported GBV cases in the latest reporting period against a target of 25,041. The matrix specifies that this indicator is non-cumulative, so the 31,460 figure should be interpreted as the latest reporting-period result rather than a cumulative project total. Reported cases can reflect incidence, awareness, access, recording practices and partner activity. The case-disposal result was six against a target of five and is therefore assessed as partially achieved. The matrix further notes that a standardized county-level disposal-time average could not be reliably verified because justice institutions maintain separate case-management systems.

5.3.2 To what extent did the project improve survivor-centered access to justice and essential services, including enhanced protection and agency of women and girls?

Summary finding. The project improved access to information, counseling, referrals, legal accompaniment, health care and selected livelihood support for women and girls who were reached. Awareness of reporting and referral pathways was high, and survivor accounts show increased confidence and psychosocial recovery. Service availability and quality varied across locations, with persistent gaps in shelters, legal aid, transport, privacy, forensic capacity and post-judgment support.

[42] End Project Results Matrix; KIIs and FGDs with coordination-mechanism members and service providers, June to July 2026.
[43] KIIs with judicial officers, police, ODPP, health providers, IPOA-linked accountability actors, and HRDs, June to July 2026.

5.3.2.1 To what extent did the project improve survivor access to justice and essential services?

Summary finding. Access improved substantially among project participants and communities linked to active partners. The reported service total exceeded the target.

The results matrix records 4,059 women and girls accessing comprehensive GBV services against a target of 1,800. Project records and interviews describe health care, psychosocial support, legal aid, accompaniment, referrals, transport, shelter placement and livelihood assistance. Police, health workers, HRDs and community organizations reported more active referral practices and additional entry points for survivors.[44]

> *"People now know that if they are violated, there is somewhere they can get justice. They also know the referral pathway."*[45]

The KAP survey supports this direction. Ninety per cent reported improved awareness of services, 93.9 percent improved knowledge of reporting, 93.9 percent improved awareness of referral pathways, and 77.5 percent agreed that access to justice and essential services had improved. The non-probability design makes these findings indicative.[46]

5.3.2.2 How accessible, timely, and survivor-centered were project-supported services and justice pathways?

Summary finding. Survivor-centered quality improved in counseling, accompaniment, selected health facilities and specialized justice settings. KAP, KII and FGD evidence indicates generally positive experiences among those reached, although timeliness and accessibility varied across institutions and counties. Recurrent service shortages remained decisive.

Survivors valued respectful counseling, accompaniment, legal information, safe spaces and continued contact with trusted community actors. Judicial and justice-sector training covered privacy, in-camera proceedings, child-sensitive practice, evidence and case timelines. The results matrix reports service satisfaction of 70.3 percent against a 70 percent target, while 77.5 percent of KAP respondents agreed that access to justice and essential services had improved. KIIs and FGDs help explain these findings: survivors particularly valued respectful counseling, accompaniment and clearer referral pathways, while service providers described improvements in privacy, referrals and survivor-sensitive case handling.[47]

These positive experiences were uneven. Survivors and service providers reported limited shelter availability and capacity, transport costs, long distances, limited privacy, court delays, threats, family pressure, weak forensic capacity and uncertainty after judgment. Child-friendly facilities and sign-language interpretation were also limited. The same barriers are considered under Human Rights in relation to dignity and non-discrimination, while this section assesses their effect on service performance.[48]

5.3.2.3 What changes occurred in women's agency, confidence, and ability to seek support and justice?

Summary finding. The project strengthened confidence, knowledge and help-seeking among women reached. Psychosocial support and peer groups were especially important. Evidence on sustained income change and reduced exposure to violence remains limited.

The project sensitized 21,602 people against a target of 25,000. Among KAP respondents, 87.8 percent reported improved awareness of rights, and 86.7 percent agreed that women and girls were more willing to seek support or report. Project participants reported stronger perceptions than non-participants. These differences are consistent with exposure and may also reflect self-selection.

> *"Before the support, I could not talk about what happened. Now I can open up, and healing has started."*[49]

The results matrix records 364 women gaining financial or vocational knowledge against a target of 300. Financial literacy, livelihood grants and vocational support addressed economic dependence and contributed to confidence for some participants. Monitoring focused on training and initial support and provided less evidence on income, business survival, household decision-making and longer-term protection.

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[44] End Project Results Matrix, Outcome Indicator 2A; KIIs and FGDs with police, health workers, HRDs, partners, and survivors, June to July 2026.
[45] KII with police gender officer, Kilifi, June 2026.
[46] KII with police gender officer, Kilifi, June 2026.
[47] End Project Results Matrix, service-satisfaction indicator; survivor FGDs and justice-sector KIIs, June to July 2026.
[48] Survivor FGDs and KIIs with police, health workers, judicial officers, HRDs, and implementing partners across the six counties, June to July 2026.
[49] FGD with survivors, Bungoma and Mt Elgon, 1 July 2026.

5.4 Efficiency

Summary finding. Efficiency was moderate. The three-year period, larger grant, dedicated project staffing, use of existing institutions, complementary partnerships, and adaptive implementation supported delivery across six counties. Annual partner contracting, delayed disbursement, staff transfers within participating institutions, uneven geographic coverage, and weak results reporting reduced efficiency. Available financial data did not support a full cost-effectiveness assessment.

5.4.1 How efficiently were financial, technical, and partnership resources utilized to deliver results in institutional strengthening, coordination, and service access?

Summary finding. Resources produced visible results across institutions, coordination structures, and survivor services. Efficiency was strongest where the project used existing systems and combined specialist technical assistance with multi-agency engagement. Geographic reach and recurrent services received less adequate coverage. Verified expenditure by outcome, county, partner, and intervention was unavailable.

5.4.1.1 To what extent were financial, technical, and human resources used efficiently to achieve project outcomes?

Summary finding. Financial, technical, and human resources supported a broad intervention package. The multi-year grant enabled wider geographic and programmatic coverage, specialized expertise supported institutional and accountability work, and dedicated project staffing supported implementation and oversight. Administrative delays, turnover among institutional counterparts, and weak monitoring reduced continuity and increased transaction costs.

Financial resources supported work across six counties and national institutions, while use of existing Court User Committees, Gender Sector Working Groups, police gender desks, health facilities, HRD networks, and partner systems reduced the need for parallel structures[50]. Technical resources combined UN Women's gender equality and programme expertise, OHCHR's human rights and accountability expertise, and specialist partner support. Human resources included dedicated UN Women Programme Analyst supported by M&E and finance personnel, alongside OHCHR human rights officers and partner teams, Senior management teams including Country and Deputy Representatives provided strategic guidance and oversight throughout implementation providing quality assurance, effective risk management and alignment with programme objectives. [51].

Annual contracting and delayed disbursement compressed implementation periods for some partners. Transfers of trained justice and service-sector personnel reduced continuity, while repeated participation by some officers limited the reach of capacity-building. Weaknesses in results monitoring also constrained the use of performance information for management[52].

> *"Each year, partners either had to renew contracts or experienced delays.[53]"*

5.4.1.2 Were project resources adequate and appropriately allocated to priority intervention areas?

Summary finding. Resources were adequate for expansion, institutional support, and selected services, but less adequate for remote outreach and sustained legal, psychosocial, transport, shelter, and livelihood follow-up.

The grant supported work in six counties and national institutions and broadened survivor assistance to include psychosocial and economic empowerment support. Reported overachievement in service reach, coordination mechanisms, and financial or vocational knowledge indicates considerable delivery in these areas.[54]

Gaps remained in remote outreach, legal aid, transport, shelter, counseling, court accompaniment, and livelihood follow-up. Some HRDs and community actors also used personal resources for transport, communication, food, and case follow-up, indicating that some delivery costs were absorbed at the community level[55].

[50] Project documents; KIIs with UN Women, OHCHR, the donor, implementing partners, and county stakeholders, June to July 2026.
[51] KII with a senior UN Women official
[52] KII with donor representative, AICS, 20 July 2026; KIIs with UN Women, OHCHR, and implementing partners, June to July 2026.
[53] KII with donor representative, AICS, 20 July 2026.
[54] End Project Results Matrix and project reports, figures reviewed in August 2026.
[55] KIIs with Partners for Justice International, health providers, justice actors, HRDs, and implementing partners, June to July 2026.

5.4.1.3 How efficiently did resource use support institutional strengthening, coordination, and survivor-centered services?

Summary finding. Practical technical assistance and multi-agency coordination generated strong returns in institutional relationships and referral practice. Service continuity remained dependent on partner financing, while broad sensitization and justice-actor coverage performed below target.

Technical assistance was particularly effective when institutions worked together around practical cases, evidence, and referral challenges. Multi-agency capacity development strengthened understanding of roles among police, prosecutors, health providers, judicial officers, and HRDs, while approaches such as case mentoring and facility-based continuing education extended learning beyond individual training events[56].

The pattern of results suggests stronger performance from intensive institutional and service support than from broad population coverage. Future allocations should therefore consider the balance between depth, geographic reach, and institutional scale.

5.4.2 To what extent did the implementation modalities and partnerships optimize value for money and timely achievement of results?

Summary finding. The partnership model effectively combined UN expertise, government authority, specialist partner capacity, and community reach. The use of existing structures supported operational efficiency, while annual agreements, administrative delays, and incomplete financial and results data reduced timeliness and limited the assessment of value for money.

5.4.2.1 How effective were implementation modalities in supporting timely delivery of activities and outputs?

Summary finding. Implementation modalities were flexible and locally adaptive. Timeliness was affected by annual renewals, disbursement delays, staff changes, security restrictions, and close-out processes.

The model combined joint agency leadership, implementing partnerships, institutional engagement, and community delivery. Partners used community champions, peer learning, barazas, safe spaces, Court User Committees, Gender Sector Working Groups, and facility-based learning to respond to local conditions[57].

Some activities were compressed or delivered intermittently. The 2024 protests temporarily restricted UN field travel, while local coordinators continued monitoring. The close-out extension to 31 July 2026 should be distinguished from substantive implementation, which ended on 31 May 2026[58].

5.4.2.2 To what extent did partnerships strengthen coordination, implementation, and accountability?

Summary finding. Partnerships were a major source of value, combining UN technical expertise and convening capacity with government mandates, specialist services, and community reach. This enabled the project to strengthen existing systems rather than establish parallel delivery structures.

UN Women provided gender equality expertise, programme management, coordination, monitoring, and quality assurance, while OHCHR contributed human rights and accountability expertise. Government institutions provided formal mandates and delivery platforms. Specialist partners added complementary capacities: CREAW supported community engagement, survivor services and referrals; IAWJ strengthened survivor-centered justice; Healthcare Assistance Kenya supported the National GBV Helpline 1195 and psychosocial referrals; and PJI provided specialized case mentoring to investigators and prosecutors. HRDs, Social Justice Centers, WROs, and survivor networks connected these institutional arrangements with communities.

Partnerships also supported coordination through Court User Committees, county structures, justice and oversight institutions, and the National GBV Gender Sector Working Group. Partner contributions were not always documented consistently, however, limiting attribution and joint learning.[59]

[56] KIIs with Partners for Justice International, justice actors, HRDs, and implementing partners, June to July 2026.
[57] Project implementation reports; KIIs with UN Women, OHCHR, partners, and county actors, June to July 2026.
[58] KII with OHCHR project personnel, June 2026; project documentation on implementation and close-out periods.
[59] KIIs with Partners for Justice International, UN Women, OHCHR, and the donor, June to July 2026.

5.4.2.3 Were institutional roles, responsibilities, and reporting arrangements clearly defined and effective?

Summary finding. Broad roles were understood among UN Women, OHCHR, the donor, public institutions, and implementing partners. Reporting provided a less complete account of progress, attribution, and resource use.

UN Women led project coordination, partner management, monitoring, and reporting, while OHCHR led or supported human rights and accountability components, including linkage between duty bearers and right holders. Government and civil society actors implemented activities, delivered services, and participated in coordination mechanisms.[11]

> *"The last annual report still had a lot of information missing on progress against the indicators."*[60]

The results matrix contained missing figures, unclear aggregation, limited disaggregation, and indicator definitions requiring confirmation. These weaknesses constrained performance assessment. A full value-for-money analysis would require verified expenditure by outcome, county, partner, and intervention type, which was unavailable to the evaluation.[61]

5.5 Sustainability

Summary finding. Sustainability prospects were mixed but generally positive. Policies, formal justice structures, skills, community networks, and working relationships have reasonable prospects of continuation. The KAP survey found that 79.5 percent of respondents believed project gains were likely to continue, with higher confidence among project participants (88.1 percent) than non-participants (65.7 percent). Services and coordination activities requiring recurrent financing remain more fragile. Staff transfers, weak county budget execution, fragmented data systems, and reliance on voluntary HRDs and community champions present material risks.

5.5.1 To what extent are strengthened institutional systems, monitoring mechanisms, and coordination platforms likely to be sustained beyond the project period?

Summary finding. Sustainability is strongest where project results are embedded in existing institutions and formal coordination spaces. Skills and relationships are likely to continue among trained actors, while financing, staff continuity, data ownership, and institutional induction will determine whether these gains become routine practice. KAP findings provide complementary evidence of confidence in continuity, although they do not establish which institutional mechanisms respondents considered most sustainable.

Evidence suggests a stronger institutional base in Kisumu, Vihiga, Bungoma and Nairobi, where the project could build on relationships and mechanisms established during earlier phases, although financing, frequent staff transfers, case delays and service gaps remain. Kilifi and Isiolo entered the programme in Phase IV and showed important gains in referral relationships, justice/service coordination and trained personnel, but had a shorter period for institutional consolidation and faced pronounced geographic and service-access constraints. Across all six counties, the evaluation therefore finds partial rather than complete sustainability: established structures and relationships can continue, while recurrently financed services, routine induction of new staff, integrated data systems and outreach to remote communities still require public investment and institutional follow-through.

5.5.1.1 To what extent have project-supported institutional systems and coordination mechanisms been institutionalized?

Summary finding. Institutionalization is partial. Formal structures, policies, focal arrangements, and HRD participation offer continuity. Several gains remain tied to specific trained individuals and active project partners.

Results embedded in existing institutions include county policies and plans, specialized courts, Court User Committee subcommittees, police and health focal arrangements, and HRD participation in formal coordination spaces. Judicial officers, prosecutors, police, health workers, and HRDs reported continued use of training and mentoring[62].

> *"What we are taught will remain in us. Even if I am transferred, I will carry that knowledge with me."*[63]

[60] KII with donor representative, AICS, 20 July 2026.
[61] End Project Results Matrix; KII with donor representative, AICS, 20 July 2026.
[62] KIIs with judicial officers, police, health workers, county officials, HRDs, UN Women, and OHCHR, June to July 2026.
[63] KII with police gender officer, Kilifi, June 2026.

Transfers may spread knowledge while reducing capacity in the original institution. New personnel did not always receive systematic induction. Integration into academies, standard operating procedures, supervision, case management systems, and continuing professional development would reduce dependence on individual staff members.

5.5.1.2 Are there adequate financial, policy, and institutional arrangements to sustain project gains?

Summary finding. Policy and institutional foundations are in place, while recurrent financing remains inadequate. Coordination, outreach, legal aid, counseling, transport, shelter, and case follow-up face the greatest financial risk.

The project supported policies, plans, petitions, and budget memoranda. County respondents emphasized that approved frameworks require budgets, released funds, facilities, and staff. Political commitment and implementation varied across counties. The five reported petitions or budget memoranda against a target of 11 indicate continued need for budget advocacy[64].

The end-project matrix reports one functioning interoperable GBV data system, through HAK 1195, against a target of three. The principal unresolved problem is that health, police, prosecution and Judiciary institutions maintain separate systems with different standards, infrastructure and data-sharing arrangements. The intended repository approach was to improve consolidation and use of GBV information across institutions, but full interoperability requires institutional agreements, common definitions and standards, privacy and data-protection safeguards, technical integration, maintenance and routine user uptake beyond what the project could complete. Sustainability therefore depends on a clearly mandated institutional owner, agreed data-governance protocols, financing for maintenance and integration into routine planning and accountability.

5.5.1.3 What factors may enable or constrain continuity of results?

Summary finding. Ownership, existing structures, trained staff, peer networks, and formal participation of HRDs and women support continuity. Public financing, staff turnover, workload, political transitions, and reliance on voluntary labour constrain it.

Government and civil society ownership, longstanding relationships, trained personnel, and peer networks were the main enabling factors. Community actors expressed strong commitment to continuing awareness, referrals, and survivor support. Some women who received livelihood assistance were reported to have maintained small businesses[65].

HRDs and community champions often used personal resources and worked without reliable compensation or protection. Their commitment supports continuity, while prolonged reliance on voluntary labour may reduce reach, quality, and safety. County leadership changes and limited budget execution create additional risks[66].

5.5.2 How durable are the changes achieved in survivor empowerment, institutional accountability, and access to justice and essential services?

Summary finding. Knowledge, confidence, peer support, referral relationships, and selected institutional practices have reasonable durability, consistent with the generally positive expectations recorded in the KAP survey. Services requiring recurrent expenditure and complex accountability processes remain more vulnerable. Continued protection, service access, and economic opportunity will determine whether individual empowerment translates into lasting change.

5.5.2.1 To what extent are gains in survivor-centered services and justice pathways likely to continue?

Summary finding. Referral knowledge and local relationships are likely to continue. The availability of counseling, legal representation, accompaniment, transport, shelter, and case follow-up depends on continued financing.

Police, health workers, HRDs, women's rights organizations, and judicial actors described established contact points and clearer referral practices. Safe spaces, survivor groups, and community champions provide local entry points. Survivors in Mt Elgon expected the referral pathway to remain because institutions now understood their roles[67].

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[64] End Project Results Matrix; county KIIs on policy implementation and financing, June to July 2026.
[65] KIIs and FGDs with government actors, partners, HRDs, community champions, and women receiving livelihood support, June to July 2026.
[66] KIIs and FGDs with HRDs and community-based responders in Bungoma, Kilifi, Isiolo, and Nairobi, June to July 2026.
[67] KIIs and FGDs with police, health workers, HRDs, WROs, judicial actors, and survivors, June to July 2026.

"Every institution has been sensitized, and each person knows their role in the hospital, police station, and court. That continued partnership will remain.[68]"

The KAP survey provides further evidence of confidence in continuity: 79.5 percent of respondents believed project gains were likely to continue. This was higher among project participants (88.1 percent) than non-participants (65.7 percent). These perceptions should be considered alongside continuing shortages of shelters, legal aid, transport, and psychosocial services[69].

5.5.2.2 How durable are institutional capacity gains and accountability improvements?

Summary finding. Capacity gains are durable at the individual level and in selected teams. Institutional durability depends on formal adoption, staff continuity, supervision, and the completion of ongoing accountability processes.

Practical case mentoring, multi-agency learning, and participation in active committees have stronger prospects than isolated training events. The Baby Pendo process created working relationships and experience in investigating and prosecuting complex violations, including international crimes. PJI emphasized the importance of retaining a consistent prosecution team for lengthy and technically demanding cases[70].

The proceedings had not concluded at the time of evaluation. Their longer-term significance will depend on the judicial outcome, continued support for witnesses and survivors, and subsequent institutional practice. Formal curricula, protocols, induction, and supervision would protect other capacity gains from staff turnover[71].

5.5.2.3 What risks may undermine continuity of women's empowerment and access to services?

Summary finding. Economic insecurity, case delays, threats, stigma, family pressure, service closures, disability barriers, and geographic isolation can weaken empowerment. Continued local networks and institutional protection are therefore central to durability.

Psychosocial recovery, legal awareness, peer support, and livelihood skills can remain with women and groups. Some participants described greater confidence and an ability to support other survivors. Financial and vocational knowledge also provides a continuing individual-level resource, although its translation into sustained economic gains depends on access to capital, markets, and continued mentoring[72].

Community champions and HRDs are likely to remain active because many were embedded in pre-existing community networks and described continued commitment to referrals and awareness work. Their contribution is nevertheless vulnerable where transport, communication, protection and case-follow-up costs are borne personally. Sustainability should therefore be understood as continued local capacity with financing and safeguarding risks, rather than as a cost-free continuation of project-supported functions.

Economic gains remain exposed to limited capital, unstable markets, household demands, and insufficient mentoring. Women in remote areas and women with disabilities face additional risks where transport and accessible services are scarce. Durable empowerment requires continued protection, economic opportunities, psychosocial support, and trusted local networks.

5.6 Gender Equality and Human Rights

Summary finding. Human rights, gender equality, and survivor-centered principles were visible in project design and many implementation practices. The project supported dignity, participation, accountability, legal awareness, psychosocial recovery, economic agency, and women's involvement in coordination. Practice remained uneven across the wider justice and service system. Disability inclusion, accessibility, disaggregated monitoring, and outreach to marginalized groups require stronger attention.

[68] FGD with survivors and community actors, Bungoma and Mt Elgon, 1 July 2026.
[69] KAP survey, n=183. Project participants, n=112; non-participants, n=71.
[70] KII with Partners for Justice International, July 2026; KIIs with OHCHR and justice-sector actors.
[71] KIIs with Partners for Justice International, OHCHR, ODPP-linked actors, and other justice institutions, June to July 2026.
[72] Survivor FGDs and KIIs with implementing partners and community actors, June to July 2026.

5.6.1 To what extent were human rights-based, survivor-centered, and gender-responsive principles integrated into project design and implementation?

Summary finding. Human rights-based, survivor-centered, and gender-responsive principles were substantially integrated through the project's objectives, partnership mix, service package, institutional capacity strengthening, and accountability work. Survivors experienced respectful counseling, accompaniment, improved access to information and services, and greater participation in selected settings. The project also introduced measures to support the inclusion of persons with disabilities, including sign-language interpretation and engagement with disability-related actors. However, persons with disabilities continued to face physical, communication, and attitudinal barriers, while institutional facilities and practices did not consistently meet standards for privacy, accessibility, timeliness, and survivor-sensitive support. Integration was therefore strong overall, but uneven for survivors facing intersecting barriers.

5.6.1.1 To what extent were human rights, gender equality, and survivor-centered principles integrated into project design and implementation?

Summary finding. Human rights, gender equality, and survivor-centered principles were strongly embedded in project design and were visible across implementation. The design linked survivor rights and agency with access to justice, accountability, essential services, and economic empowerment, while implementation translated these principles into counseling, accompaniment, referrals, legal support, and survivor participation. Integration was less consistent where institutional capacity and service availability constrained accessibility, privacy, protection, and continuity of support.

At the design level, the project linked women's and girls' rights with access to justice, public accountability, essential services, and economic agency. Its multi-level approach combined work with survivors and communities with institutional and policy interventions, while the partnership between UN Women and OHCHR brought together gender equality and human rights expertise. The intervention model also recognized the role of WROs, HRDs, and other community actors in connecting survivors with formal institutions[73].

At the implementation level, these principles were reflected in counseling, legal assistance, accompaniment, referrals, safe spaces, shelter links, transport assistance, and economic support. Survivor and community actors also participated in referral and coordination mechanisms, while some institutions adopted more confidential and survivor-sensitive approaches to case handling. The project also incorporated selected measures to improve disability inclusion, including sign-language interpretation and engagement with disability-related actors, although these measures were not consistently available across locations and services.

Implementation was nevertheless varied. Persons with disabilities continued to face accessibility and communication barriers, while privacy, safe accommodation, transport, longer-term counseling, and post-judgment support were not consistently available across locations[74]. The evidence therefore indicates strong integration in the project model, with more variable realization of these principles across institutions, counties, and different stages of the survivor pathway.

5.6.1.2 How effectively did project interventions promote dignity, participation, accountability, and non-discrimination?

Summary finding. The project substantially promoted dignity, participation and accountability through survivor-centered support, engagement of WROs and HRDs, formal coordination mechanisms, and accountability processes. Participation extended beyond representation in some settings, with community actors contributing to referrals, case follow-up and institutional discussions. Non-discrimination was addressed through selected accessibility and outreach measures, but barriers related to disability, geography, age and economic circumstances remained.

Dignity and participation were evident in counseling, peer support, accompaniment and more confidential survivor engagement. The results matrix reports women's participation in coordination mechanisms at 62.3 percent, while qualitative evidence shows that HRDs and WROs brought community concerns into Court User Committees and technical working groups, facilitated referrals, and supported case follow-up[75]. As one woman HRD explained:

[73] Project proposal and results framework; KIIs with UN Women, OHCHR, implementing partners, justice actors, and service providers, June to July 2026.

[74] UN Women Evaluation Policy, 2020; UN Women Evaluation Handbook, 2022; UN Women, Safe Consultations with Survivors of Violence Against Women and Girls, 2022.

[75] End Project Results Matrix; survivor FGDs and KIIs with HRDs, WROs, and coordination-mechanism members, June to July 2026.

"We were called to the decision-making tables. We were actively involved as community voices and responders.[76]"

This evidence suggests that participation went beyond attendance in some settings. However, the evaluation could establish more clearly who participated and what roles they played than whether their participation influenced institutional decisions, budgets or policies. The 62.3 percent figure should therefore be interpreted primarily as evidence of representation rather than decision-making influence.

Accountability was promoted through engagement with justice and oversight institutions, case mentoring, policy processes, HRD participation and support to victim representatives. The Baby Pendo process illustrates sustained multi-agency engagement in a complex accountability case. Such cases can take considerable time to conclude, particularly where they involve allegations of sexual violence by police, complex victim-support needs and protracted legal proceedings, as also demonstrated by Petition No. 122 of 2017. The Baby Pendo proceedings remained ongoing at the time of the evaluation, limiting conclusions about final accountability outcomes.

Non-discrimination was addressed through measures such as sign-language interpretation in selected activities, engagement with disability-related actors, community outreach and the use of local partners and HRDs to connect survivors with services. These measures did not consistently overcome physical and communication barriers for persons with disabilities, distance and transport constraints in remote areas, or economic and other barriers affecting underserved groups. Inclusion was therefore evident in elements of implementation but was not consistently operationalized across locations and services.

5.6.1.3 Did project-supported justice and service delivery systems reflect survivor-centered and trauma-informed approaches?

Summary finding. Survivor-centered and trauma-informed practice improved among participating actors. Repeated questioning, limited privacy, delays, witness intimidation, informal settlement, and weak post-judgment support remained common system-level gaps.

Project-supported counseling, safe spaces, HRD accompaniment, and judicial training provided practical examples of survivor-centered delivery. Training covered privacy, in-camera hearings, child-sensitive procedures, evidence, and trauma-related needs. Health workers reported improvements in referral and case management.[77]

Survivors sometimes repeated their accounts to multiple providers. Some police gender desks lacked private or child-friendly rooms, and in response to this barrier OHCHR provided 'seed equipment to gender desks of police stations in Kisumu, Kilifi and Vihiga. Counties, which drew commitments from duty-bearers to build upon this pilot demonstration by OHCHR: these commitments ought to be followed through post- programme to consolidate the gains made therein. Court delays, threats, and pressure to withdraw cases affected safety and dignity. A health respondent also raised confidentiality concerns when community actors contacted survivors without clear preparation. Consistent practice requires facilities, supervision, privacy safeguards, accessible communication, and continued service financing.[78]

5.6.2 How effectively did the project address the rights, accessibility needs, and participation of persons with disabilities and other marginalized groups in GBV prevention, access to justice, and essential services?

Summary finding. Inclusion was present in the design and in selected activities, including sign language interpretation and community-based outreach. Coverage and monitoring were uneven. Persons with disabilities, remote communities, adolescents, street-connected people, older women, and sexual and gender minorities continued to face distinct barriers and limited representation.

5.6.2.1 To what extent were accessibility and inclusion considerations integrated into project interventions?

Summary finding. Accessibility was integrated in selected activities and partnerships. It was not applied through a consistent programme-wide standard, budget, or monitoring framework.

[76] KII with woman human rights defender, Bungoma, June 2026.
[77] KIIs and FGDs with survivors, health workers, judicial officers, police, HRDs, and implementing partners, June to July 2026.
[78] Survivor and duty-bearer KIIs and FGDs across the six counties, June to July 2026.

Project documents and interviews describe efforts to include women, youth, older people, rural residents, persons with disabilities, and sexual and gender minorities. Some activities included sign-language interpretation and targeted engagement. Community-based delivery created entry points for people who might avoid formal institutions.[79]

Monitoring data did not consistently show who was reached. The KAP survey included 13 respondents identifying as people with disabilities, which is insufficient for reliable subgroup analysis. Project records provided limited disaggregation by disability, age, remoteness, and other intersecting characteristics.[80]

5.6.2.2 How effectively did the project address barriers affecting persons with disabilities and marginalized groups?

Summary finding. The project addressed some barriers through awareness, referrals, interpretation, and partner networks. Physical, communication, attitudinal, geographic, and economic barriers remained widespread.

Fifty-seven (57) per cent of KAP respondents agreed that persons with disabilities and marginalized groups continued to face service barriers. Respondents described inaccessible buildings, limited sign-language interpretation, stigma, dependence on caregivers, and low awareness of rights. Remote pastoral communities in Isiolo, villages in Mt Elgon, rural sub-counties in Kilifi, and street-connected people in Nairobi were also under-reached.[81]

> *"A deaf girl went to a police station where there was no sign-language interpreter. She was unable to report."*[82]

Adolescents, children in schools, older women caring for affected children, and sexual and gender minorities outside established partner networks also received limited targeted attention. The Relevance section considers whether these groups were recognized in the design. This section assesses whether their rights and accessibility needs were met in practice.

5.6.2.3 Were marginalized populations meaningfully included in project-supported processes and services?

Summary finding. WROs, HRDs, community champions, and survivor groups had visible roles in awareness, referral, accompaniment, and coordination. Evidence of meaningful participation by persons with disabilities and other marginalized groups was incomplete.

The admission of HRDs to Court User Committees created a formal route for community concerns to be raised in justice-sector discussions. Women's rights organizations and survivor groups also supported awareness, referrals, and local ownership. These channels increased participation among groups connected to active partners.[83]

The available data do not show participation rates, accommodation use, or outcomes for different marginalized groups. Meaningful inclusion requires early consultation, accessible venues and information, transport support, safeguarding, representative partnerships, and disaggregated monitoring. These elements appeared in parts of the project and require consistent application.

5.7 Impact

Summary finding. The evaluation identified emerging positive changes at institutional, community, and individual levels. Stronger working relationships, improved referral practices, increased awareness, greater survivor confidence, psychosocial recovery, and an active accountability pathway were the most visible changes. Social norms, service availability, case timeliness, and system-wide reform changed more gradually. The evaluation design supports contribution claims and cannot establish direct attribution.

5.7.1 What significant positive or unintended changes can be identified in relation to institutional reform, accountability, and access to justice and essential services?

Summary finding. The project contributed to significant relational and practice changes across the justice and service chain. Survivors and communities reported improved knowledge, help-seeking, and confidence. Increased demand strained limited services, staff transfers weakened continuity, and HRDs carried greater workload and exposure.

[79]Project documentation and KIIs with UN Women, OHCHR, implementing partners, and county actors, June to July 2026.
[80]KAP survey, n=183; KII with donor representative, AICS; End Project Results Matrix.
[81]KAP survey, n=183; KIIs and FGDs with persons working with marginalized groups and remote communities, June to July 2026.
[82]FGD with duty bearers and service providers, Nairobi, June to July 2026.
[83]KIIs and FGDs with HRDs, WROs, survivor groups, and Court User Committee members, June to July 2026.

5.7.1.1 What intended and unintended changes can be observed at institutional, community, and individual levels?

Summary finding. Intended changes were visible at all three levels. Unintended effects included increased service demand, heavier HRD workloads, and frequent transfers of trained staff to other locations.

Institutional actors described stronger communication, clearer roles, specialized justice arrangements, and improved referral practice. Communities reported greater awareness of rights and reporting pathways. Survivors described counseling, confidence, legal awareness, peer support, and livelihood assistance. 83% of KAP respondents agreed that project interventions contributed meaningfully to community awareness and response.[84]

> *"Before, we were working in silos. When we were brought together, we started defining our roles and referring cases more clearly."*[85]

Greater awareness increased demand for legal aid, psychosocial support, shelter, and case follow-up. Staff transfers moved trained personnel away from project sites and may spread knowledge to other locations. HRDs gained recognition but also faced higher workloads, personal costs, and potential exposure to threats.

5.7.1.2 To what extent has the project contributed to improved institutional responsiveness, accountability, and case management?

Summary finding. The project made an important contribution to responsiveness and accountability through practical training, specialized arrangements, stronger cooperation, and case mentoring. The Baby Pendo process represents a significant emerging accountability result whose final outcome remains pending.

Police, prosecutors, health workers, judicial officers, HRDs, and county actors described more direct communication and improved understanding of evidence and referral roles. Specialized court and child-justice arrangements supported more tailored handling in selected locations. The Baby Pendo case mentoring process brought investigators, prosecutors, oversight institutions, victim representatives and technical partners into sustained cooperation. It demonstrated that coordinated institutional engagement can advance accountability in emblematic cases despite complex legal processes and political-will challenges..[86]

> *"Justice has become a real concrete possibility for these kinds of crimes."*[87]

Technical support strengthened investigation, prosecution preparation, victim and witness engagement, and the use of international criminal law. The case remained ongoing. Conclusions on final accountability, precedent, and deterrence depend on the judicial outcome and subsequent institutional practice.

5.7.1.3 What changes occurred in survivor-centered access to justice and essential services?

Summary finding. Access, referral knowledge, and confidence improved among people reached by the project. Structural barriers continued to interrupt the full pathway from reporting to recovery and justice.

Survivors and community actors described greater willingness to seek counseling, report cases, approach HRDs, and follow justice processes. Psychosocial support enabled some women to move from crisis towards recovery and peer support. Economic activities provided an additional route to confidence for selected participants.88

These changes were most visible among project participants. The absence of a baseline comparison group, non-probability sampling, and possible self-selection limit conclusions about scale. Court delays, transport costs, shelter shortages, legal aid gaps, threats, informal settlements, and inaccessible facilities continued to disrupt access.[89]

5.7.2 To what extent has the project contributed to longer-term systemic change in GBV prevention and the protection of women's and girls' rights?

Summary finding. The project made an emerging contribution to longer-term change through policies, institutional capacity, specialized mechanisms, coordination structures, community awareness, and accountability work. Change was

[84]KAP survey, n=183; KIIs and FGDs across the six counties, June to July 2026.
[85]KII with woman human rights defender, Bungoma, June 2026.
[86]KIIs with justice and oversight actors, Partners for Justice International, OHCHR, HRDs, and service providers, June to July 2026.
[87]KII with Partners for Justice International, July 2026.
[88]Survivor FGDs and KIIs with HRDs, WROs, police, health workers, and implementing partners, June to July 2026.
[89] KAP survey, n=183; survivor and duty-bearer KIIs and FGDs, June to July 2026.

deeper in relationships and selected institutional practices than in system-wide financing, data integration, service availability, and social norms.

5.7.2.1 To what extent has the project contributed to broader institutional and systemic reforms in GBV prevention and response?

Summary finding. The project contributed to policy and institutional reform in selected areas. Evidence of uniform system-wide change across the six counties remains limited.

The project supported policy development and implementation, specialized justice mechanisms, institutional capacity, Court User Committees, referral arrangements, and accountability processes. By using existing institutions, it increased the likelihood that changes would influence routine systems. Women's and HRD participation brought community perspectives into formal coordination.[90]

The results matrix shows mixed progress. Coordination mechanisms and specialized justice structures performed more strongly than policy implementation, analytical products, justice-actor coverage, and budget advocacy. Longer-term reform will depend on financing, institutional ownership, staff continuity, common data systems, and continued accountability mechanisms.[91]

5.7.2.2 What evidence exists of shifts in social norms, awareness, reporting behaviour, and survivor confidence?

Summary finding. Awareness, reporting knowledge, and survivor confidence showed strong positive movement. Attitude and social norm change was more moderate and remained affected by stigma, victim blaming, family settlement, threats, and economic pressure.

KAP results show that 87.5 percent reported improved awareness of rights, 90 percent improved awareness of services, 93.9 percent improved knowledge of reporting and referral pathways, and 86.5 percent agreed that women and girls were more willing to seek support or report. These results align with qualitative accounts of improved knowledge and help-seeking.[92]

Sixty-five per cent agreed that communities had become less accepting of violence against women and girls, while 62 percent agreed that men and boys were increasingly involved in prevention. Increased reporting may reflect awareness, incidence, recording, access, and partner activity. The evidence therefore supports stronger knowledge and help-seeking among groups reached, with gradual movement in broader norms.[93]

5.7.2.3 How has the project contributed to the protection of women's and girls' rights over time?

Summary finding. The project strengthened protection by connecting rights awareness with public institutions, survivor services, coordination, accountability, and economic support. Reach and durability varied by location, disability, age, social identity, and access to active partner networks.

Women connected to project-supported partners described increased ability to identify violations, seek assistance, and participate in coordination processes. Public institutions and civil society actors also gained knowledge, relationships, and mechanisms that support protection and access to justice.[94]

Remote communities, persons with disabilities, adolescents, street-connected people, and other marginalized groups continued to face greater barriers. Service shortages and weak financing limited protection after awareness and reporting increased. Sustained financing, stronger institutionalization, accessible services, improved data, and representative participation will determine the project's longer-term contribution.

[90]End Project Results Matrix; KIIs with national and county institutions, HRDs, WROs, and project partners, June to July 2026.
[91]End Project Results Matrix, provisional version reviewed August 2026; KIIs with government, donor, and project stakeholders.
[92]KAP survey, n=183 consenting respondents, analysis conducted August 2026.
[93]KAP survey, n=183; community and duty-bearer KIIs and FGDs, June to July 2026.
[94]Survivor FGDs and KIIs with public institutions, WROs, HRDs, and implementing partners across the six counties, June to July 2026.

6. Conclusions

The evaluation concludes that *Let It Not Happen Again: Safeguarding the Rights of GBV Survivors Through Access to Justice* was a relevant and substantially effective intervention that addressed important weaknesses in Kenya's GBV prevention, justice and essential-service systems. Its main contribution was combining institutional strengthening, coordination, community engagement, and direct survivor support. The project generated meaningful changes, while persistent financing, staffing, geographic and service-delivery constraints affected the depth and sustainability of results.

	Conclusion	Evaluative judgement
1.	The project addressed the interconnected barriers to GBV prevention, access to justice and essential services.	The project was well aligned with the legal, institutional, social, economic and geographic barriers affecting survivors and the institutions responsible for GBV prevention and response. Its multi-level approach, three-year duration and expansion to six counties strengthened contextual responsiveness. Reach nevertheless remained varied within counties, particularly in remote areas and among some marginalized groups. The Theory of Change captured the main institutional and survivor pathways but underestimated their non-linear nature, including setbacks caused by economic dependence, threats, family pressure, transport costs, service shortages and lengthy proceedings.
2.	Strengthened coordination and relationships across institutions and communities were among the project's most significant achievements.	Court Users Committees, gender technical working groups, specialized subcommittees and referral networks strengthened communication, clarified responsibilities and improved referral relationships among police, justice institutions, health providers, county actors, HRDs, WROs and other service providers. These changes addressed an important source of fragmentation in the GBV response system. Their durability remains affected by staff transfers, dependence on active focal persons and external facilitation, and fragmented institutional data systems.
3.	Survivor-centered interventions produced meaningful changes for women and girls reached.	Psychosocial support, legal information, accompaniment, referrals and community-based support responded to important survivor needs. KAP and qualitative evidence indicate improved awareness of services and reporting pathways, greater confidence in seeking assistance and psychosocial benefits among those reached. HRDs, WROs and community actors were important in helping survivors navigate institutions. The survivor pathway remained constrained by uneven availability of shelter, transport, sustained legal assistance, witness protection, longer-term counseling and post-judgment support.
4.	The project strengthened institutional capacity and selected accountability mechanisms, although institutional change was uneven.	Training, practical mentoring, specialized justice arrangements and multi-agency engagement contributed to improvements in knowledge and practice among participating justice and service actors. The accountability component also strengthened cooperation around the Baby Pendo case, which continues to be protracted given the legal complexities and perceived outcomes of accountability for police commanders. Staff transfers, limited coverage and uneven integration of learning into institutional systems reduced the extent to which individual capacity gains became routine institutional practice.
5.	Sustainability is strongest for knowledge, relationships and formally embedded mechanisms, while services requiring recurrent financing remain vulnerable.	Working through existing institutions increased the prospects that policies, coordination mechanisms, referral relationships and acquired knowledge will continue. Sustainability is less certain for coordination meetings, outreach, legal aid, counseling, transport, shelter and case accompaniment because these require recurrent resources. Reliance on HRDs and community champions who sometimes use personal resources also creates sustainability risks. Longer-term continuity will depend on converting project-supported practices into adequately financed institutional responsibilities.
6.	Gender equality, human rights and survivor-centered principles	The project incorporated dignity, participation, accountability, psychosocial recovery and women's agency across its interventions. Survivor groups, WROs and HRDs participated in awareness, referrals, accompaniment and coordination. Implementation was less consistent for

	Conclusion	Evaluative judgement
	were substantively integrated, while inclusion and accessibility require more systematic operationalization.	persons with disabilities, remote communities, adolescents and other underserved populations. Inclusion therefore requires clearer accessibility standards, dedicated resources, representative partnerships and stronger disaggregated monitoring.
7.	The monitoring and results architecture did not adequately capture the complexity of the changes the project sought.	The results framework captured implementation scale but provided less information on institutional practice, service continuity, survivor pathways, accessibility and durability of change. Questions about aggregation, unique beneficiary counts, disaggregation, indicator definitions, and verification of some reported results further constrained the assessment. Future monitoring should follow the Theory of Change more closely and combine output measures with indicators of institutional change, survivor experience, accessibility, service continuity and sustainability.

7. Recommendations

The seven recommendations below are derived from the triangulated findings and conclusions, together with forward-looking suggestions gathered through KIIs and FGDs. They were refined following review by members of the Evaluation Reference Group, the donor, UN Women and OHCHR, and consideration of the GERAAS assessment. The evaluator incorporated review inputs where supported by evidence, while retaining independent judgment. The review process also helped clarify the feasibility, prioritization and institutional responsibilities associated with each recommendation.

Several of the constraints identified by the evaluation extend beyond the mandate of a single organization and therefore require differentiated responsibilities. Government institutions have primary responsibility for actions related to public systems, financing, and institutional mandates, while UN Women, OHCHR, AICS/development partners, and civil society have complementary roles based on their respective mandates and comparative advantages. The recommendations should be considered as a connected package, although their sequencing differs. R1–R4 and R6 warrant immediate or short-term attention because they focus on consolidating existing gains, continuity of survivor support, inclusion, community-level response capacity and stronger results monitoring. R5 requires sustained engagement with national and county institutions and alignment with government planning and budget cycles. R7 should inform the design of any subsequent joint programme or continuation of the partnership model.

The recommendations also reflect the need for future programming to give greater attention to consolidation and institutional depth when considering geographic expansion. The project demonstrated the value of working simultaneously at institutional, community and survivor levels, while also showing that increased awareness and reporting can generate additional demand for services whose availability and accessibility vary across locations. Decisions on future geographic coverage should therefore consider institutional capacity, local partnerships and the availability of survivor services required to maintain continuity across the intervention pathway.

No.	Priority recommendation and proposed actions	Primary responsibility	Supporting responsibility	Priority/timeframe	Linked conclusion
R1	***Strengthen and sustainably resource existing multi-sectoral GBV coordination, referral and justice mechanisms.*** Strengthen the functionality of CUCs, Gender Technical Working Groups and other established mechanisms; clarify referral and focal-person responsibilities; integrate GBV and survivor-centered competencies into institutional training and induction; and progressively finance coordination functions through regular public budgets.	- National and county governments - NCAJ/Judiciary - NPS; ODPP - health authorities - State Department responsible for Gender	- UN Women - OHCHR - WROs and HRDs - Italy/AICS and other development partners	**High** / Short to medium term	**C2, C4, C5**
R2	***Strengthen continuity of survivor-centered support from reporting through longer-term recovery.*** Strengthen county referral pathways and institutional responsibilities for health and psychosocial support, legal aid, accompaniment, transport, shelter and safe accommodation, protection and post-judgment support. Link economic empowerment more systematically to recovery, mentoring and economic reintegration.	- National and county governments - relevant justice, health and social-service institutions	- UN Women - OHCHR - WROs - HRDs - specialized service providers - development partners	**High** / Immediate and continuing	**C1, C3, C5**
R3	***Strengthen monitoring and reporting of inclusion, accessibility and intersecting vulnerabilities.*** Systematically disaggregate participation, service	- UN Women	- OHCHR - implementing partners	**High** / Immediate and continuing	**C1, C6**

No.	Priority recommendation and proposed actions	Primary responsibility	Supporting responsibility	Priority/timeframe	Linked conclusion
	access and outcomes, including for persons with disabilities and other underserved groups, and document the accessibility measures provided and remaining communication, physical, geographic and other barriers.	- relevant government institutions	- organizations of persons with disabilities - WROs and HRDs		
R4	***Strengthen and adequately resource HRDs, WROs and community-based responders within GBV systems.*** Support survivor accompaniment, referrals, transport and communication alongside safeguarding, protection, digital security, psychosocial wellbeing and continuing technical support. Strengthen their formal participation in coordination and accountability structures.	- National and county governments - UN Women - OHCHR	- Justice institutions - WRO and HRD networks - Implementing partners - Italy/AICS and other development partners	**High** / Short term and continuing	**C2, C3, C5**
R5	**Deepen national and county ownership by linking GBV commitments to recurrent public financing and institutional responsibilities.** Identify and progressively finance recurrent costs associated with coordination, outreach, shelters, psychosocial services, legal support, transport and other essential functions. Track budget allocations, releases and expenditure so that increased public financing translates into stronger institutional ownership and continuity of results.	- National and county governments	- UN Women - OHCHR - civil society - Italy/AICS and other development partners	**High** / Medium term	**C2, C5**
R6	***In future programming, strengthen the results framework and monitoring system to better capture institutional change, survivor pathways, inclusion and sustainability.*** Establish clear indicators, baselines, targets, aggregation rules and responsibilities; distinguish unique beneficiaries from repeat service contacts; strengthen disaggregation; and measure institutional practice, service quality, survivor experience, accessibility, referral completion and sustainability. Clarify the ownership and functionality of the interoperable GBV repository.	- UN Women	- OHCHR - relevant government institutions - Implementing partners	**Medium** / Before design of a subsequent phase	**C7**
R7	***Retain the complementary UN Women–OHCHR partnership while strengthening joint planning, accountability support, contribution tracking and learning.*** Maintain the complementary gender equality and human rights mandates with appropriate resourcing. Strengthen joint workplans, reflection and reporting. Continue specialized support to accountability pathways for serious GBV and human rights violations, including institutional capacity, victim participation and protection, and cooperation among investigative, prosecutorial, oversight and justice institutions and civil society.	- UN Women - OHCHR	- NPS - IPOA - ODPP - KNCHR - Judiciary - WROs and HRDs - Specialist partners - Italy/AICS and other development partners	**Medium** / Future programme design and implementation	**C2, C4, C7**

8. Lessons Learned

The evaluation identified the following lessons for future programming on GBV prevention, access to justice and survivor support. They reflect implementation experience across the six project counties and the national-level institutional component.

	Lesson	Key learning from the project	Implication for future programming
1.	GBV programming needs to address the full survivor pathway.	Survivors often require several forms of support, including information, health care, reporting, legal assistance, psychosocial support, protection, shelter and economic support. These pathways are rarely linear. Transport costs, threats, family pressure, economic dependence and service shortages can interrupt progress even after a survivor has entered the justice or service system.	Programme design and Theory of Change frameworks should anticipate interruptions and integrate flexibility of adjustment, repeated engagement and movement between services. Referral pathways should connect prevention, justice, protection and longer-term recovery.
2.	Relationships across institutions and communities are an important form of institutional capacity.	Court User Committees, technical working groups, referral networks and multi-agency engagement strengthened communication among police, prosecutors, courts, health workers, county actors, HRDs and service providers. Knowing whom to contact and understanding each actor's role improved referrals and case follow-up.	Institutional strengthening should invest heavily in multi-agency relationships, referral practice and joint problem-solving alongside technical training.
3.	Practical mentoring and repeated engagement can deepen institutional learning.	Case mentoring and practical multi-agency engagement allowed justice and service actors to apply knowledge and receive feedback. Staff transfers and rotations reduced the durability of capacity-building that remained attached to individual participants.	Training should be combined with mentoring, institutional curricula, induction, supervision and continuing professional development so that knowledge becomes embedded within institutions.
4.	Increased awareness and reporting need corresponding service capacity.	Community awareness and legal literacy increased knowledge of reporting and referral pathways. Greater awareness can also increase demand for health services, legal aid, psychosocial support, shelter, transport and accompaniment. These services remained unevenly available.	Awareness and prevention activities should be planned alongside realistic assessments of service capacity so that increased reporting can be matched with accessible and continuous support.
5.	Community-based actors extend institutional reach, but require adequate support.	HRDs, WROs, community champions and survivor networks connected survivors with formal institutions and supported referrals and case follow-up. Some relied on personal resources for transport, communication and other case-related costs.	Community-based responders should be formally recognized and supported through appropriate resources, safeguarding, technical assistance and stronger institutional connections.
6.	Geographic expansion needs to consider depth of coverage within counties.	Expansion to six counties increased geographic diversity, while substantial inequalities remained within counties. Remote communities often had weaker access to police, courts, health facilities and project partners than populations near county and sub-county centers.	Geographic scope should be determined by service availability, partner presence and the ability to maintain functioning referral pathways. County coverage should therefore be assessed together with within-county reach.
7.	Inclusion requires operational arrangements as well as commitments in programme design.	Persons with disabilities, remote communities, adolescents and other underserved populations continued to face physical, communication, geographic and economic barriers. Inclusion measures were implemented in some activities but were not consistently applied across the programme.	Inclusion should be translated into accessibility standards, appropriate partnerships, reasonable accommodation, dedicated resources and disaggregated monitoring from programme design onwards.

	Lesson	Key learning from the project	Implication for future programming
8.	Monitoring systems for complex GBV programmes need to track pathways and quality of change.	Counts of trainings, beneficiaries and mechanisms captured implementation scale but provided less information on survivor pathways, service continuity, institutional practice and longer-term change. Aggregation and disaggregation weaknesses also affected interpretation of some results.	Results frameworks should follow the Theory of Change and combine output measures with indicators of institutional practice, survivor experience, accessibility, referral completion, service quality and sustainability.

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Appendices

1.	**Appendix 1**	**Evaluation Terms of Reference** **https://drive.google.com/file/d/1aPj1RsNQRh6Yru9TF7r9p569bGwBDt20/view?usp=sharing**
2.	Appendix 2	Evaluation Matrix https://drive.google.com/file/d/1WN_ihbIRpTpwpH_xhlv221teMOB_HIYe/view?usp=sharing
3.	Appendix 3	List of Documents Reviewed https://drive.google.com/file/d/1tucD_NNgKbrUiGCCXvEU3gX_8KbePKKV/view?usp=sharing
4.	Appendix 4	Stakeholder matrix/Participant Profile and Institutions Consulted https://docs.google.com/spreadsheets/d/1ESyl1i8OS4-RRhW-B3bIERb8oy9aVP9i/edit?usp=sharing&ouid=105484407317274734149&rtpof=true&sd=true
5.	Appendix 5	Data Collection Tools: KII and FGD Guides https://drive.google.com/file/d/1e60RfYYp_Xda-hqqbQH1xuPb7M-OlLHu/view?usp=sharing
6.	Appendix 6	KAP Survey Questionnaire https://drive.google.com/file/d/1vGqq6e0S_yTXBoBAyWbn9cq63k_NTaH2/view?usp=sharing
7.	Appendix 7	KAP Survey Results/Dataset_Anonymized https://docs.google.com/spreadsheets/d/1R1LqiaN0HwiFNAUTqxiuP5_28iFbSUyS/edit?usp=sharing&ouid=105484407317274734149&rtpof=true&sd=true
8.	Appendix 8	End Project Results Matrix https://docs.google.com/spreadsheets/d/1ukgOsfW1Suqry2RRtYzXvjkeQFwli1S1/edit?usp=sharing&ouid=105484407317274734149&rtpof=true&sd=true