

# Ex post evaluation

## Development of the health sector, Kenya



<b>Title</b>	Development of the health sector (reproductive health HIV/AIDS prevention)		
<b>Sector and CRS code</b>	Reproductive health care (CRS code 1302000)		
<b>Project number</b>	2004 65 245		
<b>Commissioned by</b>	Federal Ministry for Economic Cooperation and Development (BMZ)		
<b>Recipient/Project-executing agency</b>	Ministry of Health, formerly Ministry of Health and Sanitation		
<b>Project volume/Financing instrument</b>	EUR 7.5 million (budget funds)		
<b>Project duration</b>	22 September 2006 to 14 June 2018		
<b>Year of report</b>	2022	<b>Year of random sample</b>	2019

### Objectives and project outline

The objective at outcome level was to increase the demand for and use of family planning services by the entire sexually active and poverty-affected population of reproductive age and to contribute to reducing gender-based disadvantages. At impact level, the aim was to make a structural contribution to reducing infant/child and maternal mortality and combating HIV/AIDS.

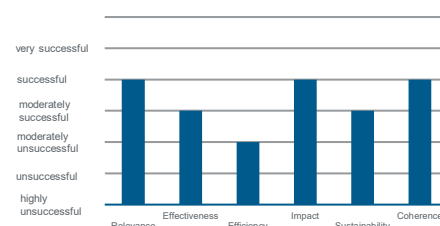
The aim was to provide modern and needs-based contraceptives as well as education and advisory activities geared towards behavioural change. In addition, preparatory work should be done to participate in the design and implementation of sector policy through a sector-wide approach (SWAp). However, it turned out that the health sector in Kenya was not prepared to participate in a SWAp, as the partner could not perform the necessary management and coordination tasks. For this reason, the development partners, including German DC, decided not to participate in a SWAp.

### Key findings

The project is rated as moderately successful overall. The main reasons can be summarised as follows:

- The efficiency of the project was limited by the enormous time delay and the resulting large gap between the realisation of the components as well as the implementation of inadequate preparatory work for the implementation of the SWAp.
- The sustainability of the project is at risk due to the strong donor dependence in the provision of contraceptives as well as the abrupt discontinuation of the information and behaviour change campaign without securing a sustainable willingness to finance from the partner.
- The lack of early warning indicators to identify the partner's lack of performance in coordination and management tasks meant that it was not possible to react promptly, flexibly, and efficiently to changed framework conditions.

**Overall rating:**  
moderately successful



### Conclusions

- Women's social position remains a critical success factor for development effectiveness.
- Sufficient and resilient capacities of the partner and its willingness to implement are essential for the implementation of demanding components.
- The efficiency of the project could have been increased by using the direct payment process.
- The digital behaviour change campaign can be transferred to similar regions and target groups. To secure lasting success, implementation should be linked to continuation by the partner.

## Rating according to DAC criteria

**Overall rating: 3**

### Ratings:

Relevance	2
Coherence	2
Effectiveness	3
Efficiency	4
Overarching developmental impact	2
Sustainability	3

### General conditions and classification of the project

The project evaluated here (BMZ 2004 65 245) is a continuation and conceptual development of the three previous FC projects Family Planning I, II and III and was intended to promote three components: (1) Provision of modern and needs-based contraceptives through both the public and private sectors, (2) target-group-specific education and advisory measures to improve the use of reproductive health services and increase demand for contraceptives, and (3) preparatory work to participate in the design and implementation of sector policy under the Sector-Wide Approach (SWAp). The component (1) will be continued by the FC projects (BMZ 2007 65 131 and BMZ 2010 66 943), which also continue the social marketing of clinical family planning (social franchising) from the Family Planning III project. This approach also helps to reduce misconceptions among the target group with regard to modern contraceptive methods and to increase their willingness to engage in continuous family planning, and thus supports component (2) of the project under evaluation (BMZ 2004 65 245). The content of the follow-up projects (BMZ 2007 65131 and BMZ 2010 66 943) is taken into account in the evaluation. Family Planning I has already been evaluated and rated as still satisfactory with an overall rating of 3<sup>1</sup>.

### Breakdown of total costs

Budget funds of EUR 7.5 million were provided for the project. The counterpart contribution of the Kenyan side amounted to EUR 0.9 million.

		2004 65 245 (planned)	2004 65 245 (actual)
Investment cost	EUR million	8.40	8.40
Counterpart contribution	EUR million	0.90	0.90
Financing	EUR million	7.50	7.50
of which budget funds	EUR million	7.50	7.50

### Relevance

At the time of the project appraisal (PA) in 2005, the situation in the Sexual and Reproductive Health Department (SRH) in Kenya was highly unsatisfactory and worrying. Kenya was one of the countries with the worst key health indicators<sup>2</sup>: maternal mortality (590 per 100,000 live births) and infant and child mortality (114 and 76 per 1,000 live births). Although the HIV/AIDS prevalence rate had been declining, it was still the seventh highest in the world at 6.7%.<sup>3</sup>

<sup>1</sup> For Family Planning II and III, see Coherence section.

<sup>2</sup> Infant mortality in Kenya ranks 149th out of 196.

<sup>3</sup> The key indicators are based on World Bank data, 2022, <https://data.worldbank.org>.

Around 90% of the total population had no access to adequate supply of services to maintain or improve their SRH. This primarily affected 8.6 million women (26% of the total population (2005)) of reproductive age (15 to 49 years). With average population growth of 2.4%, their share of the total population was forecast to reach 10.5 million by 2015; Kenya's population was one of the fastest growing in Africa.

The number of births per woman (fertility rate) had fallen continuously since the introduction of the family planning programme in 1968 (from an average of 8.1 births in 1977 to 4.7 births in 1998). This trend stagnated primarily among socially disadvantaged contraceptive users after the turn of the millennium<sup>4</sup> and increased to an average of 4.8 births in 2003. The average number of children Kenyan women wanted to have was 3.9 children, which was below the fertility rate, indicating an unmet need for family planning methods. Only about half of women were involved in decisions concerning their own health care. Around 78% of newly married women were in favour of a longer interval between births or against having children. Overall, about 20% of the births were unwanted and 25% were planned for a later date.

The contraceptive prevalence rate for modern methods<sup>5</sup> was around 39% among married women in the year of the PA, 2005, and differed drastically between income groups, school education and by urban/rural areas. Around 53% of all women used SRH public service providers, while 41% used private providers. Shortages in the supply of modern contraceptives by the public health system also occurred repeatedly nationwide and/or supra-regionally, and it was foreseeable at that time that available stocks would only last until March 2006. High drop-out rates among users also indicated a clear need for improved information and advice in order to convey knowledge about the relationship between the number of children, health status, poverty in the household and reproductive rights. Women's dissatisfaction with family planning services stood at 24%.

The underlying results chain for the project is also plausible from today's perspective:

Through (1) target-group-specific education and advisory measures to improve the use of reproductive health services and to increase the demand for contraceptives and (2) the provision of modern and needs-based contraceptives through the public and private sector, the use of family planning services is increased by the entire sexually active poverty-affected population of reproductive age (target group) and a contribution is made to reducing gender-specific disadvantages (outcome). It seems plausible that the increase in the use of modern family planning methods contributes to reducing the fertility rate and thus to preventing deaths and illnesses of women in connection with pregnancies and births and also to reducing unwanted pregnancies and at-risk births and thus to reducing infant and child mortality. It is also plausible to assume that a change in sexual behaviour contributes to preventing HIV/AIDS in view of the targeted increase in protected sexual intercourse. Contributions to health sector reform through assistance for the planned SWAp support the overall framework within which the project operates.

The measures were geared towards the development policy needs of the target group (as outlined above), which encompasses the entire sexually active and poverty-affected population of reproductive age, in particular women and girls as well as young people, mothers and children.

Furthermore, the project approach corresponded to the German and international development policy priorities valid at the time the project was designed, which were expressed in MDG 4 (reduce child mortality), MDG 5 (improve maternal health) and MDG 6 (combat HIV/AIDS, malaria and other diseases).

From today's perspective, the project is still relevant and met expectations.

### Relevance rating: 2

### Coherence

The project has a high level of internal coherence, as it involves the conceptual further development of ongoing German support in the reproductive health subsector. In the past, this support included the FC-

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<sup>4</sup> All in all, there are several explanations for this stagnation. Political unrest and subsequent economic difficulties in Kenya in the 1990s as well as the resulting educational gaps are often cited as the reason for the stagnation of birth rates in the 2000s (Kebede et al. (2019): Stalls in Africa's fertility declined partly as a result of disruptions in female education, Proceedings of the National Academy of Sciences).

<sup>5</sup> Condoms, the birth control pill, three-month injections, IUDs and hormone implants are defined as modern methods.

financed programmes for the supply of contraceptives, procurement and a social franchising approach (Family Planning I – III; BMZ numbers 1995 66 597; 1999 65 955 and 2000 65 664). The cooperation project “Development of the Health Sector” for the subsidy of defined SRH services (BMZ no. 2002 66 338) is also located in the sector. Specific synergy effects arise in the SRH sub-sector due to the integration of FC and TC components. For example, intensive TC support for the SWAp was planned, but this could not be fully implemented due to the changed project processes.

We see an important contribution to this in the joint representation of the German DC projects agreed with the MoH (Ministry of Health) in a regular steering committee led by the State Secretary at the MoH. Overall, the project is well embedded in German DC with Kenya and consistent with other German DC measures and principles. The measures were in line with the partner government’s priorities under the second National Health Sector Strategic Plan (NHSSP II) for the period 2005 to 2010. The NHSSP is an integral part of the national Economic Recovery Strategy for Wealth and Employment Creation (ER-SWEC) and forms the basis for medium-term financial planning prepared by the Ministry of Finance. In addition, the module was based on the Kenyan Ministry of Health’s National Reproductive Health Strategy (NRHS).

The design of the measure is in line with the activities of other donors, mainly USAID and DFID, in the reproductive health department in terms of external coherence. In particular, reference must be made here to the “DELIVER” project by USAID, which supports the government drug procurement and distribution agency Kenya Medical Supply Agency (KEMSA) in matters relating to the procurement, storage and distribution of drugs. In addition, further financing of contraceptives, for example, was coordinated and achieved.

In line with the partner’s own efforts, the project is well embedded in the national strategy for reproductive health and is based on MoH activities. As already mentioned, the measures were in line with the partner government’s priorities under the National Health Sector Strategic Plan II (NHSSP II) for the period 2005 to 2010.

From today’s perspective, internal coherence would no longer be ensured, as German DC is exiting the health priority area.

Overall, the coherence of the project meets expectations.

**Coherence rating: 2**

### Effectiveness

The objective at outcome level was to increase the demand for and use of family planning services by the entire sexually active and poverty-affected population of reproductive age (target group) and to contribute to reducing gender-specific disadvantages. In addition, contributions by German DC to health structure reform were planned by supporting the SWAp.

The three components of the project were (1) the provision of modern and needs-based contraceptives, (2) target-group-specific education and advisory measures, and (3) preparatory work for participation in the design and implementation of sector policy within the scope of the SWAp.

The first component covered a large part of the financial volume and included the procurement and distribution of modern contraceptives by KEMSA.

Two information and behaviour change campaigns were carried out with the second component. A first campaign was launched in 2012 with printed educational materials. After the disposition fund used for this purpose was closed in 2014, a second digital campaign was carried out from September 2020 to April 2021 in accordance with COVID-19 regulations. Tujulishane, the nationwide information and behaviour change campaign (“Let’s Educate Each Other”), was first developed through tests with potential target groups. The focus of the campaign in line with the COVID-19 guidelines was: reproductive and maternal health, sexual and gender-specific violence, adolescent sexual and reproductive health, and family planning. The target group was women of reproductive age, young people aged 10–24, men as partners of women of reproductive age and healthcare providers in all 47 counties of Kenya. The focus was on the dissemination of information by influencers and mainstream media as well as the establishment of a con-

tact centre with a toll-free telephone number. The campaign ended in April 2021 and the contact centre closed.

As the health sector cannot be financed domestically in the long-term, the original objective was to sustainably minimise the discrepancy between Kenya’s economic opportunities and the health services offered by means of a SWAp (component three). The primary aim was not to expand the health sector, but to improve all health services in the long term within the scope of coordinated measures to use the available own and donor funds more efficiently. Sustainability was to be improved through increased effectiveness and efficiency of the use of funds and the MoH was to be strengthened in its role as a regulator. However, the third component could not be implemented as planned because the Kenyan partners were unable to carry out the management and coordination tasks required for this. The development partners, including German DC, decided not to participate in the SWAp.

The following indicators were used as part of the evaluation to measure target achievement at outcome level: (1) Contraceptive prevalence rate, (2) Unmet need for family planning, (3) First-time mothers aged 15 to 19 and (4) Supply of short-term contraceptives.

Indicator	Status PA, target PA	Ex post evaluation
(1) Contraceptive prevalence rate	<p>Married women: -All methods<sup>6</sup> 39% (2003), 62% (2010) -Modern methods<sup>7</sup> 32% (2003)</p> <p>All women: -All methods<sup>8</sup> 28.4% (2003) -Modern methods (no data available)</p>	<p>Married women: -All methods<sup>5</sup> 65% (2020) -Modern methods<sup>6</sup> 61% (2020)</p> <p>All women: -All methods 45.7% (2019)<sup>9</sup> -Modern methods<sup>9</sup> 44.9% (2021)</p>
(2) Unmet need for family planning decreases among married women	<p>24.5% (2003)<sup>7</sup>, 6% (2010)</p> <p>“Unmet need for limiting birth”: 10.1% (2003)<sup>7</sup></p> <p>“Unmet need for spacing birth”: 14.4% (2003)<sup>7</sup></p>	<p>15.0% (2019)<sup>10</sup></p> <p>“Unmet need for limiting birth”: 6.7% (2019)<sup>9</sup></p> <p>“Unmet need for spacing birth”: 8.3% (2019)<sup>9</sup></p>
(3) Proportion of first-time mothers aged between 15 and 19 years	23% (2003), 10% (2010)	7.5% (2015–2020) <sup>11</sup>
(4) The proportion of healthcare facilities offering the full spectrum of short-term contraceptives is increasing	73% (2004), 80% (2010)	89% (2018) <sup>12</sup>

<sup>6</sup> <https://data.worldbank.org/indicator/SP.DYN.CONU.ZS?locations=KE>

<sup>7</sup> <https://data.worldbank.org/indicator/SP.DYN.CONM.ZS?locations=KE>

<sup>8</sup> Kenya Demographic and Health Survey (2003), <https://dhsprogram.com/pubs/pdf/fr151/fr151.pdf>

<sup>9</sup> Kenya Family Planning, <http://www.track20.org/ext/countryData.php?code=kenya>

<sup>10</sup> PMA 2020, [https://www.pmadata.org/sites/default/files/data\\_product\\_results/PMA2020-Kenya-R7-FP-brief.pdf](https://www.pmadata.org/sites/default/files/data_product_results/PMA2020-Kenya-R7-FP-brief.pdf)

<sup>11</sup> UNDP Human Development Report 2020

<sup>12</sup> Final inspection 2018

Indicator 1: The contraceptive prevalence rate (all methods) for married women increased from 39.3% to 58.0% between 2005 and 2014 instead of the planned 62.0%. The target value was achieved for the first time in 2015 (64.7%) and improved again after a decline (65.1%; 2020). With regard to the application of modern methods, the contraceptive prevalence rate for married women in 2014 was 53.4%, rose to 62.4% by 2015 and stood at 61.2% in 2020.

While the contraceptive prevalence rate (all methods) among all women was still 28% in 2003, this was increased to 46% by 2019.

Three-month injections (DMPA) and hormonal contraceptive implants (hormone implants) were offered as a priority and were in demand among both married and unmarried women. The birth control pill was ranked third among married users, while condoms worn by the male partner ranked third among unmarried users<sup>13</sup>. The mix of modern contraceptives is reflected in the selection of contraceptives procured under the project (DMPA, hormone implants and the birth control pill). This made it possible to make a customised selection based on the women's priorities in terms of effectiveness and menstrual cycle control, the side effects and risks as well as potential therapeutic or preventive goals.

High prevalence rates have been achieved in Kenya compared with neighbouring countries<sup>14</sup>. The fact that the contraceptive prevalence rate did not increase further is due to the continuing difficulties in supply and the lack of donor-independent financing for needs-based and modern contraceptives in Kenya.

Indicator 2: Unmet need for family planning indicates the extent to which women are able to achieve their desired family size and spacing between births, or points to the gap between women's reproductive intentions and their contraceptive behaviour. It also provides information on the success of reproductive health programmes in meeting the demand for services. The indicator complements the contraceptive prevalence rate by indicating the additional extent of the need to delay or limit births. The target of reducing the (overall) unmet need for family planning from 24% in 2003 to 6% by 2010 seems extremely ambitious in retrospect: the rate fell to 15% by 2019.

With regard to the desired family size or the spacing between births, the "unmet need of limiting birth"<sup>15</sup> fell from 10.1% (2003, married women) to 6.7% (2019, married women) and the "unmet need of spacing birth"<sup>16</sup> from 14.4% to 8.3% for the same period. By reducing unwanted pregnancies, including the associated physical and disease burden due to insufficient spacing between births, both a reduction in infant/child<sup>17</sup> and maternal mortality can be contributed to (impact at impact level).

Indicator 3: The proportion of first-time mothers aged between 15 and 19 decreased from 23% (2003) to 15% (2014). As a result, the target value could not be achieved in the target period. In retrospect, this indicator is also considered too ambitious; the share is still high (7.5%, 2015–2020).

Indicator 4: The proportion of healthcare facilities offering the full spectrum of short-term contraceptives was even exceeded with 89% instead of the planned 80%. The indicator is intended to capture the aspect of qualitative improvement in the supply of short-term contraceptives. However, it makes no statement about the use of the range of products and services (outcome level) or about the degree of supply of the target group with modern and needs-based contraceptives in the sense of the total market approach (now state-of-the-art)<sup>18</sup>.

<sup>13</sup> PMA 2020,

<sup>14</sup> The corresponding contraceptive prevalence rates among married women in neighbouring countries are: Ethiopia 38% (2020), Somalia 7% (2019), Tanzania 38% (2016) and Uganda 50% (2021) (World Bank, 2022, [https://data.worldbank.org/indicator/SP.DYN.CONU.ZS?locations=KE-SO-TZ&most\\_recent\\_value\\_desc=false](https://data.worldbank.org/indicator/SP.DYN.CONU.ZS?locations=KE-SO-TZ&most_recent_value_desc=false))

<sup>15</sup> This indicator describes the unmet need for birth restriction, i.e. women who do not want children but do not use contraception.

<sup>16</sup> This indicator describes the unmet need for delayed birth, i.e. women who would like to have a greater spacing between births, but do not use contraception.

<sup>17</sup> "Children born at least three years apart but less than five years apart are 1.5 times more likely to survive the first seven days, 2.2 times more likely to survive the first 28 days, 2.3 times more likely to survive the first year and 2.4 times more likely to reach the fifth year of life compared with children born less than two years apart." (World Vision, 2022, <https://www.wvi.org/maternal-newborn-and-child-health/healthy-timing-and-spacing-pregnancies>).

<sup>18</sup> The "total market approach" refers to a system in which the public sector, the private sector and hybrid forms work together effectively to serve all segments of the population.



The following picture emerges with regard to supplying the target group via the public and private sector: Between 2014 and 2018, an average of 95.6% of public sector establishments offered three or more family planning methods and an average of 65.2% offered five or more family planning methods. There was a high availability of three-month injections (80.2%), IUDs (65.7%), hormonal implants (79.9%) and the birth control pill (74.2%)<sup>19</sup>. However, there were sometimes no stocks in the private sector. IUDs, three-month injections and hormonal contraceptive implants were less widely offered by the private sector. At 70.5%, the birth control pill was frequently available in the private sector. Access to condoms via both the public and private sectors was consistently ensured at 90%<sup>20</sup>.

The information and behavioural change campaigns are regarded as fundamentally expedient and sensible for achieving the project's objectives. However, the campaigns did not take place simultaneously with the implementation of component 1, i.e. they took place after the provision of the contraceptives in each case.

With regard to the second campaign, the use of social media is considered sensible, especially with regard to the COVID-19 regulations, but also to reach the young target group. Mass media such as radio were also used, which meant that as many people as possible could be reached at home. This meant that vulnerable groups and rural residents could also be reached. The inclusion of men in the target group and the consideration of different languages and cultural differences within Kenya must be seen as positive – in particular with regard to the reduction of gender-specific disadvantages. However, it was also noted during the survey that fundamental social causes are difficult to change.

By providing and simplifying access to free contraceptives, the measure contributed to achieving the objectives at the level of disadvantaged and vulnerable groups. As already mentioned, this was also promoted through information and behavioural change campaigns, albeit at different times. The target values of the indicators were partially achieved in the planned period and at the time of the EPE.

Overall, effectiveness can be rated as moderately successful.

**Effectiveness rating: 3**

### Efficiency

Due to delays in project implementation and conceptual changes, the project took a total of 139 months to implement. Originally, a total length of 36 months was planned, with implementation starting at the end of 2006. The main reasons for this delay included the closure of the disposition fund and the associated subsequent implementation of the second campaign, which did not start until 2020. With the closure of the disposition fund, it was possible to identify and use remaining funds for the second campaign. There was also a delay in the distribution of contraceptives.

The most important component of the project included the provision of modern and needs-based contraceptives in the amount of around EUR 5.6 million and covered the largest share of the project's costs at 74.6%. The average price per CYP (Couple-Years of Protection) was EUR 3.56 and is therefore below the UNFPA Contraceptive Price Indicator. Consequently, the procurement costs of the contraceptives in this project were comparatively low. The consulting costs associated with procurement in the amount of EUR 10,840 are also considered low. The procurement and distribution of contraceptives took place as a counterpart contribution of the government via KEMSA. This centralised mechanism enabled the funds provided to be used efficiently and coordinated with national efforts to be distributed according to needs and to avoid duplication of efforts. In addition, the project benefited from the existing structures of KEMSA, as they knew the country and were prepared for any hurdles in the distribution process. However, there were delays in the cooperation with KEMSA and it became apparent that the supply of remote areas and people with disabilities could not always be ensured completely or only with difficulty. The reasons for this were presumably the capacities at KEMSA and the institutional crisis that KEMSA experienced in 2008/09. The distribution of contraceptives was demand-based.

<sup>19</sup> PMA 2020, Performance Monitoring for Action, [www.pma2020.org](http://www.pma2020.org)

<sup>20</sup> PMA 2020 Performance Monitoring for Action, [www.pma2020.org](http://www.pma2020.org)

From the point of view of allocation efficiency, it is still unclear whether a purely demand-based distribution of contraceptives was sensible, as regions with previously low demand received little support as a result.

Another critical aspect is the unclear distribution of contraceptives between public and private facilities. It is not possible to track how many contraceptives were delivered to private or public facilities. Private facilities and pharmacies dispense contraceptives for a fee, thus reducing the individual positive effect for the recipients of the contraceptives.

The target-group-specific education and advisory measures and the preparatory work for participation in the design and implementation of sector policy within the scope of the SWAp should be implemented using two disposition funds. The Ministry of Health should provide extensive expertise with TC support. It became apparent that the administration of the disposition fund by the executing agency without consulting support did not make sense and that even TC support could only compensate for this to a limited extent. Due to a lack of capacity, the Ministry of Health did not take on its coordination and management tasks as requested, particularly in the SWAp process. The decisive reasons for this were capacity deficits as well as absences and overburdening of key managers. For example, the officer at the Ministry of Health who was specifically nominated for the FC measures at the beginning of 2012 is on transitional leave without a successor having been named for this function until her return. In addition, according to reports, the political crisis and restructuring of the government were the reasons for the stagnation of the SWAp process. For management and efficiency reasons, both disposition funds were closed by Germany's FC at the end of 2014, which led to a possible loss of efficiency due to the costs of closing the disposition funds, but definitely resulted in an unnecessary delay in the implementation of the project. The measures continued under the direct reimbursement procedure.

Although the contraceptives covered the needs from 2007 to 2009 and the implementation of this component was concluded in 2010, the first campaign on target-group-specific education and advisory measures started late due to the inefficient management of the disposition fund and ended later in 2017.

For reasons of efficiency, the emerging available project funds (EUR 0.7 million) could have already been used at this time to cover the increased demand for contraceptives. However, the residual funds should instead be used in consultation with the Ministry of Health in awareness campaigns in conjunction with social media campaigns as well as print media and merchandising products. Due to COVID-19, the funds for print media and merchandising products were used to support the ongoing digital campaign with a focus on social media and online consultations, which was the most effective way to successfully complete the measures, taking into account the changed framework conditions caused by COVID-19. This campaign was carried out from September 2020 to April 2021. The focus on digital delivery channels was intended to secure the effectiveness of the campaign, as many people were at home and predominantly consumed digital content. This was the ideal channel, especially for the target group of adolescents, especially since schools were closed. During the current health-related restrictions on freedom of movement, the population was particularly dependent on digital information platforms from the Ministry of Health.

Due to the short duration of eight months of the "second" campaign and the closure of the contact centre, the component is not very efficient. It is estimated that the cost of continuing to run the campaign and contact centre is relatively low compared with the one-time costs required to set it up. The lack of funds to continue running the campaign was also identified as one of the biggest problems in the partner survey. In addition, there is the ongoing churn of trained personnel.

With regard to the proposed SWAp, it would have been sensible in retrospect to choose an independent project for this challenging approach. The funds earmarked for this purpose, as well as the funds for co-financing the budget study, could have been used more sensibly for the procurement of needs-based and modern contraceptives – directly at the time when it was clear that the SWAp would not materialise.

Overall, the use of local structures and the low procurement and consulting costs in the area of contraceptives can be rated as positive, as can the comparatively efficient contraceptive component, which, at almost 75%, accounts for a large proportion of the project in terms of costs. However, this was countered by



the termination of the participation in the SWAp and the enormous time delay, which led to a large gap in the implementation of components (1) and (2).

Therefore, the efficiency is rated as moderately unsuccessful.

**Efficiency rating: 4**

**Overarching developmental impact**

The overarching developmental objective (impact level) was to make a structural contribution to reducing infant, child and maternal mortality and combating HIV/AIDS and thus to contributing to the development goals formulated at national level, which were in line with the UN Millennium Development Goals (MDGs 4, 5 and 6). The infant, child and maternal mortality rates and HIV/AIDS prevalence are used as indicators for target achievement, and are complemented by the HIV incidence rate and fertility rate indicators as part of the EPE. The following picture is shown:

Indicator	Status PA, target PA	Ex post evaluation
Maternal mortality rate (number of deaths per 100,000 live births)	590 (2005); 560 (2008) (MDG: 147 (2015))	342 (2017)
Child mortality (deaths per 1,000 live births) <sup>21</sup>	76 (2005) (MDG: 33 (2015))	42 (2020)
Infant mortality (deaths per 1,000 live births)	114 (2005); 110 (2008) (MDG: 25 (2015))	31 (2020)

Source: All data is based on World Bank data.

Overall, maternal mortality was significantly reduced from 590 (2005) to 342/100,000 live births (2017). Maternal mortality is therefore below the sub-Saharan Africa average of 534 (2017).

The use of modern contraceptives can help reduce maternal mortality by preventing unwanted pregnancies, high-risk pregnancies or illegal abortions, and by generally reducing the number of births per woman<sup>22</sup>. For example, a model by Cleland et al. (2012) shows that for each percentage point increase in contraceptive use, maternal mortality can be reduced by 8.5 cases per 100,000 live births<sup>23</sup>. Specifically, 2,340,000 unwanted pregnancies and 6,000 cases of maternal mortality were prevented in Kenya in 2021, which can be attributed to the use of modern contraceptives<sup>24</sup>.

Contraceptives can also help to reduce infant and child mortality, especially by increasing the spacing between births already discussed. If all births were to occur at intervals of at least two years, the mortality rate of one to four year-olds could be reduced by 21% and infant mortality by 10% (Cleland et al., 2012). Specifically, child mortality (deaths per 1,000 live births) in Kenya was reduced from 76 (2005) to 42 (2020) and infant mortality (deaths per 1,000 live births) from 114 (2005) to 31 (2020).

HIV/AIDS prevalence fell from 6.8% at the time of the PA to 4.0% in 2021. The indicator was already achieved in 2008 (6.0%). In principle, it should be noted that treating HIV/AIDS with antiretroviral drugs has a positive effect on the HIV/AIDS prevalence rate and this effect must be considered when interpreting the results. The HIV/AIDS incidence rate fell from 3.0% to 0.72%.

<sup>21</sup> Inconsistent indicators of child, infant and neonatal mortality were used throughout the project cycle.

<sup>22</sup> Stover & Ross (2014): Erratum to: How Increased Contraceptive Use has Reduced Maternal Mortality. *Maternal and Child Health Journal*, 18(1), 333–333.

<sup>23</sup> Cleland et al. (2012): Contraception and health. *The Lancet*, 380(9837), 149-156.

<sup>24</sup> Kenya Family Planning 2030, <http://www.track20.org/Kenya>

Indicator	Status PA, target PA	Ex post evaluation
HIV/AIDS prevalence rate (15–46 year-olds)	6.8% (2005), 6% (2010)	4.0% (2021)
HIV incidence rate (total)	3.0 (2005)	0.72 (2020)

Source: All data is based on World Bank data.

The fertility rate indicator indicates that the project contributed to improved reproductive health. The fertility rate fell from 4.9 births per woman in 2003 to 4.6 births in 2008–09 and further to 3.9 in 2014, which is a remarkable decrease of one child within 10 years. By contrast, the target of 3.5 births for 2010 was not achieved (4.37). At the time of the EPE, the fertility rate of 3.37 (2020) was below Sub-Saharan Africa’s high average of 4.56 (2020)<sup>25</sup>.

Indicator	Status PA, target PA	Ex post evaluation
Fertility rate (total fertility rate) <sup>26</sup>	4.9 (2003), 3.5 (2010)	3.37 (2020)

Source: All data is based on World Bank data.

Methodologically, it is, of course, fundamentally important to note that the impacts at impact level cannot be assigned directly or exclusively to the project due to the comparatively small scope of the project and the multiple factors that influence it (attribution problem).

Overall, due to the positive trends of all indicators and the plausible results chain, it can be concluded that the project has had a positive overarching developmental impact, although the available data and the problem of causal attribution do not allow a clear conclusion to be drawn.

### Overarching developmental impact rating: 2

#### Sustainability

The two main risks to the sustainability of the project are the existing donor dependency and lack of self-financing in the procurement of contraceptives, as well as the social position of women in Kenya as the cause of maternal mortality and HIV prevalence.

The Kenyan side fulfilled its share of the financing of contraceptives by 25% at the scheduled time in accordance with the implementation agreement. However, as already discussed, it was not possible to secure additional financing. Although the right to high-quality health care has been enshrined in the Kenyan Constitution since 2010<sup>27</sup> and the government’s budget funds for family planning have also risen considerably from USD 2.5 million (2005) to USD 17.49 million (2017), it has still not been possible to motivate the Kenyan government to finance a significant proportion of the contraceptives to date. It remains unclear whether financing is really not possible or not desired. Other donors have therefore repeatedly stepped in at short notice to continue financing the contraceptives. FCDO<sup>28</sup> and USAID<sup>29</sup> in particular took over large parts of the financing of contraceptives after the end of the project evaluated here, so that supply bottlenecks were avoided. As a result, it has not yet been possible to decrease the considerable donor dependency in the procurement of needs-based and modern contraceptives<sup>30</sup>, so that the sustained provision of needs-based and modern contraceptives for a target group of poorer users, which has grown in recent years, is at risk. A long-term positive impact of the project through the establishment of sustainable financ-

<sup>25</sup> <https://databank.worldbank.org/source/world-development-indicators>

<sup>26</sup> Births per woman

<sup>27</sup> GIZ, 2022, <https://www.giz.de/de/weltweit/19798.html>

<sup>28</sup> Foreign, Commonwealth & Development Office

<sup>29</sup> United States Agency for International Development

<sup>30</sup> Following the withdrawal of the USAID, FCDO is currently financing family planning projects in Kenya in particular

ing is inhibited. No structural change and integration of the measure into the health system was achieved, for example through a continuation of the campaign or a long-term and larger increase in expenditure on contraceptives. In addition, only 5% of ODA funds from external donors are channelled to the health sector and German DC is withdrawing completely from the health sector<sup>31</sup>. In the 2020/21 financial year, EUR 14.9 million would have been required to finance family planning. However, a total of only EUR 11.6 million could be provided, resulting in a shortfall of EUR 3.3 million. The largest donors were UNFPA, the World Bank and the Global Fund<sup>32</sup>.

Another problem was the decentralisation of the health sector in Kenya because the federal states responsible for procurement and, in some cases, the financing of contraceptives were largely overwhelmed with the new tasks and are still partially overwhelmed. The reform stemmed from the new constitution adopted in 2010 and was initially mainly characterised by unclear responsibilities and staff shortages in remote areas<sup>33</sup>. Occasionally, this also led to strikes among health care personnel<sup>34</sup>. However, this should not be a problem in the medium term after the start-up difficulties usually associated with such reforms.

Since the health sector cannot be financed from national funds over the long term, the aim was to minimise the discrepancy between Kenya's economic opportunities and the health services offered in the long term by means of a SWAp. Preparatory work to participate in the design and implementation of sector policy under a SWAp could not be implemented as planned. The risk identified at the PA that the SWAp process in the health sector in Kenya could potentially not be successfully advanced has been confirmed.

It is also very difficult to measure the sustainability of the behavioural change campaign. It is questionable whether the campaign has achieved a sustainable effect or only a one-off effect. In particular, the scrapping of the toll-free number of the contact centre has worked against the sustainability of the project, as the operation of the contact centre, although very successful and well-known, had to be discontinued. As already explained, there is also a lack of further financing here. This was also listed in the partner survey and was identified as one of the project's biggest problems. In addition, the social position of women and girls remains one of the causes of maternal mortality and HIV prevalence in Kenya. Early marriage, stigmatisation and non-acceptance of contraceptives have emerged as one of the risks to the success of the project. In the survey of partners in the EPE, it was also confirmed that social patriarchal structures continue to be an obstacle to the implementation of reproductive rights.

The project's positive developmental effectiveness is likely to decline significantly, but will remain positive, as other donors such as FCDO, UNFPA, the World Bank and the Bill & Melinda Gates Foundation are currently active in the area of family planning in Kenya and will continue to be so in the foreseeable future. For this reason, the sustainability of the project has been satisfactory since its conclusion and with a view to the future.

**Sustainability rating: 3**

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<sup>31</sup> KENYA: BMZ Country Strategy 2018–2024, p. 7

<sup>32</sup> DESIP (2021): Increasing domestic financing for family planning commodities in Kenya, [https://options.co.uk/sites/default/files/desip-funding-fp\\_v6.pdf](https://options.co.uk/sites/default/files/desip-funding-fp_v6.pdf)

<sup>33</sup> GIZ (2014): [https://www.giz.de/projektdaten/projects.action?request\\_locale=de\\_DE&pn=201321470](https://www.giz.de/projektdaten/projects.action?request_locale=de_DE&pn=201321470)

<sup>34</sup> KMA Online (2013): Doctors' strike in Kenya paralyses hospitals, <https://www.kma-online.de/aktuelles/panorama/detail/aerztstreik-in-kenia-legt-krankenhaeuser-lahm-a-27707>

### Notes on the methods used to evaluate project success (rating)

Projects are evaluated on a six-point scale, the criteria being **relevance, coherence, effectiveness, efficiency, overarching developmental impact and sustainability** and a final **overall rating** of the development effectiveness. The scale is as follows:

<b>Level 1</b>	very successful: result that clearly exceeds expectations
<b>Level 2</b>	successful: fully in line with expectations and without any significant shortcomings
<b>Level 3</b>	moderately successful: project falls short of expectations but the positive results dominate
<b>Level 4</b>	moderately unsuccessful: significantly below expectations, with negative results dominating despite discernible positive results
<b>Level 5</b>	unsuccessful: despite some positive partial results, the negative results clearly dominate
<b>Level 6</b>	highly unsuccessful: the project has no impact or the situation has actually deteriorated

Rating levels 1–3 denote a positive assessment or successful project while rating levels 4–6 denote a negative assessment.

The **overall rating** on the six-point scale is compiled from a weighting of all six individual criteria as appropriate to the project in question. Rating levels 1–3 of the overall rating indicate a “successful” and levels 4–6 an “unsuccessful” project. It should be noted that a project can generally be rated developmentally “successful” only if the achievement of the project objective (“effectiveness”), the impact on the overall objective (“overarching developmental impact”) **and** the sustainability are rated at least “moderately successful” (level 3).