Ex Post-Evaluation Brief
Kenya: Family Planning and Combating Sexually Transmitted Infections/AIDS

Programme/Client	Family Planning and Combating Sexually Transmitted Infections/AIDS – BMZ no. 1995 66 597	
Programme executing agency	Ministry of Health (MoH)	
Year of sample/ex post evaluation report: 2012*/2012		
	Appraisal (planned)	Ex post-evaluation (actual)
Investment costs (total)	EUR 5.11 million	EUR 5.57 million
Counterpart contribution (company)	EUR 0.00 million	EUR 0.50 million
Funding, of which budget funds (BMZ)	EUR 5.11 million EUR 5.11 million	EUR 5.07 million EUR 5.07 million

* random sample

Project description: The programme was appraised 1995 and implemented between 1998 and 2006. It included the nationwide supply of oral contraceptives, medical apparatus and instruments for clinic-based family planning procedures (sterilisation), together with basic medication and consumables for the treatment of sexually transmitted infections (STIs). Public and private NGOs (Marie Stopes and Family Health Options). Additionally, the programme financed a consultant to support the procurement and distribution of the financed deliveries.

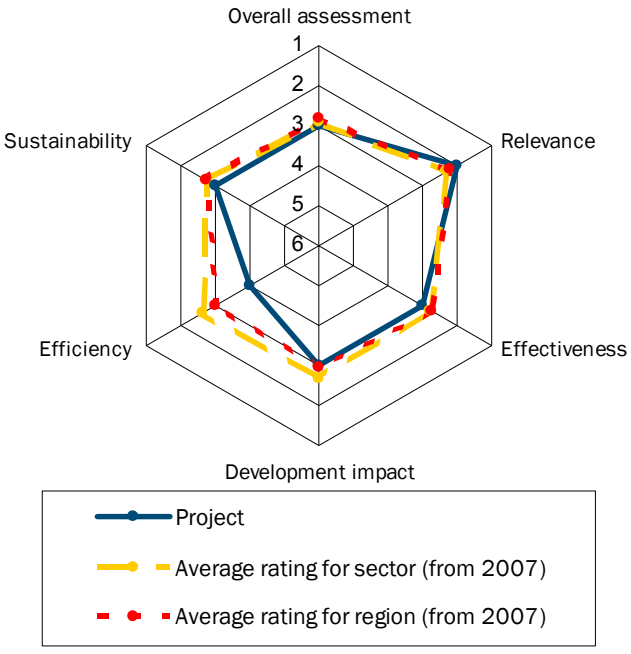
Objective: The overall objectives for the contraception component developed during the ex-post evaluation were "to contribute to containing population growth and improving women's health", with overall objective indicators defined as "a reduction in both the fertility rate and the maternal mortality rate". The overall objective for the STI component was "to contribute to containing the spread of STIs", the overall objective indicator being "a fall in the incidence of STIs". Programme objectives were defined as increasing the demand (1) for oral contraceptives and clinic-based family planning methods and (2) for treatment from those with STIs. The programme objective indicators were, in the case of the contraception component, the modern contraceptive prevalence rate and the level of unmet demand for family planning among married women, and, in the case of the STI component, the number of STI treatments carried out.

Target group: The project's immediate target group were women aged between 15 and 49; however, indirectly the group also included newborns, infants and young children, as well as men suffering from STIs, predominantly from poorer strata of the population. The size of the target group was not quantified during programme appraisal. Currently, around 8.6 million women of reproductive age are living in Kenya.

Overall rating: 3

On the basis of field visits, local discussions and statistical evaluation, the programme has been assessed as still satisfactory. This evaluation is derived from a good score for relevance, mixed results in terms of progress made towards programme objectives, unsatisfactory efficiency (due to the lengthy implementation period), and unsatisfactory findings on sustainability.

Rating by DAC criteria



EVALUATION SUMMARY

Overall rating: The overall rating from ex-post evaluation of this programme is "satisfactory" (Rating: 3).

Relevance: The programme appraisal report identified the high rate of fertility and population growth, a high level of maternal mortality, and the widespread prevalence of STIs (gonorrhoea, chlamydia, and syphilis) as the core problems. The inadequate provision of services in women's health and family planning were identified as the root causes. Even today, limited access to - and the lack of demand for - goods and services promoting reproductive health, together with the unsatisfactory extent of progress made in the area of maternal health, still represent key problems for the Kenyan health sector. In essence, the programme's chain of impact – providing STI medications and modern methods of family planning to increase their availability, and thereby contribute to better sexual and reproductive health - was a plausible approach, and still is. However, it should be noted that improved availability alone is still no guarantee for an increased demand for contraception; other factors, including knowledge of family planning methods and women's freedom of choice, also play a role. Containing the rapid growth in population is still a priority for the Kenyan Government. Given this population growth, distributing contraceptives free of charge represents the correct approach also in retrospect. However, from today's perspective, extending the programme to include free-of-charge provision within a Social Marketing framework (a "total market" approach), as it took place in the follow-up programmes, is an important tool for reaching the different target groups specifically. Reducing maternal mortality conforms to MDG 5 and, equally, represents a national development priority. Furthermore, for the German development cooperation, the health sector and family planning continue to be priority areas in its cooperation with Kenya. At the time of programme appraisal, contraceptives were, at least in part, provided in a parallel and rather uncoordinated fashion by the donors. Today, formalised meetings between donors take place at regular intervals. In these meetings, which are led by the Ministry of Health, the quantity of contraceptives required and the financing thereof are determined together. The programme has helped to initiate this process. The Ministry's involvement here shows that it takes its monitoring and control function very seriously. Overall, the programme's relevance is rated as "good". (Sub-Rating: 2).

Effectiveness: At programme appraisal, the programme objectives were defined as follows: (1) contributing to maintaining a supply of oral contraceptives, (2) contributing to the provision of clinic-based methods of family planning, and (3) contributing to improving the prevention, diagnosis and treatment of STIs. According to the programme appraisal report, progress towards objectives was to be measured using the following indicators: (a) providing 600,000 couple years of protection, (b) appropriately meeting the demand for sterilisation in at least 10 public district hospitals and 24 NGO establishments, and (c) providing 3.5 million STI treatments. From today's perspective, the programme objectives relating to contraception should be reformulated as "increasing the demand for oral contraceptives and clinic-based family planning methods in the programme area", and the objective for the STI component should similarly be restated as "increasing the demand for treatment among those suffering from STIs". From to-

day's standpoint, the "couple years of protection" indicator (indicator a) which was set at programme appraisal should not be applied at the programme objective level but at the level of results. Alternative indicators were established for the purposes of ex-post evaluation. For the contraception component, the indicator used was the modern contraceptive prevalence rate, together with the level of unmet demand for family planning services among married women (aged 15-49), expressed in percentage terms; and for the STI component, the number of STI treatments carried out was used as an indicator. Nationally, the modern contraceptive prevalence rate has improved considerably, from 27.3% at programme appraisal in 2003, to 39% in 2008. Unmet demand remains unchanged at 25%, which suggests that not only the usage of modern contraceptives has increased (as shown by the contraceptive prevalence rate), but that acceptance of their usage has also improved. With regard to STI treatments, the final review in 2009 finds that only 200,000 were carried out under the programme instead of the forecast 3.5 million. However, it seems reasonable that the number quoted in the final review was a typographical error, and that 2 million STI treatments were actually carried out. This assumption is based on the estimated cost per STI treatment as well as the actual expenditure for this programme component, which ultimately came out a third lower than planned. To summarise the evaluation of the STI indicator: the supplied STI treatment kits were used for their intended purpose, and hence it is reasonable to assume that there is a demand by those suffering from STIs, although the actual number of treatments performed was below the target value. Taken altogether, effectiveness has been assessed as "satisfactory" (Sub-Rating: 3).

Efficiency: Programme implementation faced substantial delays, originated in part by the lengthy discussions over contract details and payment terms which took place between the Ministries of Health and Finance, the Kenya Medical Suppliers Agency (KEMSA), and the suppliers. As a result, programme implementation took 118 months instead of the 36 months estimated at the time of programme appraisal. Partially as a result of this prolongation, consultancy costs increased from EUR 0.15 million to EUR 0.33 million; however, this is still acceptable, since it also includes costs of around EUR 100,00 for the Chagua Langu contraceptive pill. A further cause of delay was the lack of clarity regarding financing for the distribution costs incurred by the Kenya Medical Suppliers Agency (KEMSA), which were not covered by the Ministry of Health's budget. This led to irregular deliveries, which at times caused shortfalls in the supply of contraceptives and STI medication. A total of 615,385 couple years of protection were provided, slightly above the planned figure of 600,000. The participating NGOs - Marie Stopes Kenya and Family Health Options – implemented their programmes as planned. KEMSA has significantly improved its logistics system since then, including through the introduction of a management information system. Delivery services were subcontracted to private transport companies two years ago. According to KEMSA, contraceptive supply shortages no longer arise. This has been confirmed in interviews conducted with public and private health institutions, but only with regard to pills and condoms. Shortages do occur, especially in the supply of implants and emergency contraceptive pills, which are in high demand. In summary, it has to be stated that efficiency was no longer satisfactory (Sub-Rating: 4).

Overarching developmental impact: In the programme appraisal report, the overall objective was designated by contributing to the reduction of the fertility rate and thereby to reduction of maternal mortality. No separate overall objective was defined for the STI component in the appraisal report. From today's perspective, the overall objectives formulated in the appraisal report include indicators, and they were also used as such in the context of the evaluation. The overall objectives were subsequently defined during ex-post evaluation as (1) to contribute to containing population growth and (2) to contribute to improving women's health (the overall objective indicators being a reduction in both the fertility rate and the maternal mortality rate). For the STI component, (3) containing the spread of STIs represents an appropriate overall objective; the reduction in STI prevalence should be used as an indicator. Since programme appraisal in 1998, the fertility rate (4.6 in 2008) remains largely unchanged. Female mortality figures have worsened, growing from 400/100,000 to 488/100,000. However, since end users are utilising the supplied contraceptives for their intended purpose, it can be assumed that fertility and maternal mortality rates would have deteriorated even further without this programme. This also suggests that medical care for pregnant women and mothers has been unable to keep pace with the high rate of population growth – with corresponding adverse effects on maternal mortality. Furthermore, this high maternal mortality rate is caused by the number of home births, which remains at a high level (56% of all births), and the complications that arise with it. Since the implementation of the programme here under review, approaches used in FC-funded follow-up programmes in the family planning domain (Phases II and III) have been further developed. Hence Phase II is supporting the Social Marketing and Franchising approach adopted by the Marie Stopes NGO, and the range of contraception and family planning methods on offer is being expanded in Phase III. This programme, Family Planning Phase I, can be seen as an entry programme for German financial cooperation into the family planning domain in Kenya, whereas more widespread effects are only becoming apparent following the launch of the follow-up programmes. As well as AIDS, STIs basically include sexually transmitted infections such as syphilis, chlamydia, gonorrhoea and type 2 herpes (HSV-2). According to the 2008 Kenya Demographic and Health Survey, 2% of the women questioned and 1% of the men stated that they had an STI or STI symptom. Since no baseline data is available for the time of programme appraisal, it is not possible to assess how STI prevalence has developed. However, the supplied STI treatment kits were used as predetermined, and it is reasonable to assume that their use contributed to containing the spread of STIs. Taken altogether, overarching developmental impact is ranked as no more than satisfactory (Sub-Rating: 3).

Sustainability: Contraceptives are still being given out free-of-charge by public institutions. At the time of programme appraisal, the supply of contraceptives was 90% dependent on donor support. Currently, this number stands at around 80%. The Ministry of Health has certainly increased its share of financing, which presently stands at KES 0.5 billion (approx. EUR 5 million), rising from 10% to 34% in 2005/06 and from 41% in 2009/10. However, facing the rapid population growth and the government's budgetary constraints, maintaining contraceptive supplies in the future will still be largely dependent on external financing. Their increased contribution demonstrates that providing support for family planning is a high priority for the current government. The programme has contributed to the creation of sustainable structures for harmo-

nising donor interventions in the family planning domain, and these are being strengthened and expanded in the follow-up programmes. In addition, the programme serves as a basis for the introduction of a “total market” approach, as adopted in the follow-up programmes. Since donor support for family planning can be expected to continue in the future and sustainable structures for donor coordination have been established, and KEMSA now has a generally well-functioning logistics system for supplying contraceptives (which can also be attributed to the work of the funded procurement consultant), it is also reasonable to assume that a reliable supply of contraceptives will be provided in future. Taken altogether, the programme’s sustainability has therefore been marked as satisfactory (Sub-Rating: 3).

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

Projects (and programmes) are evaluated on a six-point scale, the criteria being relevance, effectiveness, efficiency and overarching developmental impact. The ratings are also used to arrive at a final assessment of a project's overall developmental efficacy. The scale is as follows:

1	Very good result that clearly exceeds expectations
2	Good result, fully in line with expectations and without any significant shortcomings
3	Satisfactory result – project falls short of expectations but the positive results dominate
4	Unsatisfactory result – significantly below expectations, with negative results dominating despite discernible positive results
5	Clearly inadequate result – despite some positive partial results, the negative results clearly dominate
6	The project has no impact or the situation has actually deteriorated

Ratings 1-3 denote a positive or successful assessment while ratings 4-6 denote a not positive or unsuccessful assessment

Sustainability is evaluated according to the following four-point scale:

Sustainability level 1 (very good sustainability) The developmental efficacy of the project (positive to date) is very likely to continue undiminished or even increase.

Sustainability level 2 (good sustainability): The developmental efficacy of the project (positive to date) is very likely to decline only minimally but remain positive overall. (This is what can normally be expected).

Sustainability level 3 (satisfactory sustainability): The developmental efficacy of the project (positive to date) is very likely to decline significantly but remain positive overall. This rating is also assigned if the sustainability of a project is considered inadequate up to the time of the ex post evaluation but is very likely to evolve positively so that the project will ultimately achieve positive developmental efficacy.

Sustainability level 4 (inadequate sustainability): The developmental efficacy of the project is inadequate up to the time of the ex post evaluation and is very unlikely to improve. This rating is also assigned if the sustainability that has been positively evaluated to date is very likely to deteriorate severely and no longer meet the level 3 criteria.

The overall rating on the six-point scale is compiled from a weighting of all five individual criteria as appropriate to the project in question. Ratings 1-3 of the overall rating denote a "successful" project while ratings 4-6 denote an "unsuccessful" project. It should be noted that a project can generally be considered 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 "satisfactory" (rating 3).