



SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Evaluation of the development-policy area of intervention

2025

Through its area of intervention “Population dynamics; sexual and reproductive health and rights”, Germany’s Federal Ministry for Economic Cooperation and Development (BMZ) is working together with its partners to strengthen sexual and reproductive health and rights (SRHR). In this evaluation the German Institute for Development Evaluation (DEval) examines and assesses the activities in the area of intervention. The findings of the evaluation show that many interventions succeed in strengthening SRHR in partner countries. However, most interventions focus on the health-related aspects of the area of intervention. It is much less common for them to focus on strengthening sexual and reproductive rights. For example, the sexual and reproductive autonomy of girls and women, or aspects of their bodily integrity, are rarely addressed. As a result, fewer impacts are achieved in these areas. Furthermore, people from marginalised groups in practice often still face barriers to accessing SRHR services and products.

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IMPRINT

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- Germany’s umbrella organisation of development and humanitarian non-governmental organisations, the Verband Entwicklungspolitik und Humanitäre Hilfe deutscher Nichtregierungsorganisationen (VENRO), and the civil society organisations nominated by it – Deutsche Stiftung Weltbevölkerung (DSW), CARE Germany, medica mondiale and Plan International Germany.

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EXECUTIVE SUMMARY

Background and aims of the evaluation

Strengthening sexual and reproductive health and rights (SRHR) is a global task. Despite previous successes in strengthening SRHR worldwide, challenges persist in the fight against maternal and neonatal mortality, as well as unintended and early pregnancies and gender-based violence (GBV). In many places the sexual and reproductive rights of girls and women are realised either not at all, or only partially. The importance of SRHR as a development-policy challenge is also reflected in the 2030 Agenda and its Sustainable Development Goals (SDGs), which contain numerous direct and indirect references to SRHR.

Through its area of intervention “Population dynamics; sexual and reproductive health and rights”, Germany’s Federal Ministry for Economic Cooperation and Development (BMZ) is working together with its partners to improve SRHR. Development cooperation interventions in partner countries aim to contribute to improving the quality and accessibility of sexual and reproductive health (SRH) services. They also aim to realise the sexual and reproductive rights (SRR) of girls and women and other marginalised groups more extensively.¹

Promoting SRHR is a politically and strategically important area for German development policy. At the time of the evaluation, promoting SRHR was part of the BMZ’s development policy priority areas, as demonstrated by the multiple references to SRHR in the strategy for a feminist development policy (BMZ, 2023a).² The Coalition Agreement of the German Federal Government elected in 2025 also emphasises SRHR as an important area of development policy (German Federal Government, 2025). Moreover, the relevance of SRHR to development cooperation is also reflected in the many interactions with other core areas, such as education and training, employment promotion, economic development and good governance (BMZ, 2023b). Furthermore, by international comparison Germany is one of the key bilateral actors for promoting SRHR (BMZ, 2023c; DSW, 2023).

In this evaluation the German Institute for Development Evaluation (DEval) examines and assesses German development cooperation’s activities to promote SRHR worldwide. The evaluation is designed first of all to support further development of the SRHR area of intervention in German development cooperation. Its findings should supply information on which interventions and approaches have been successful to date, and how the area of intervention and activities within it can be improved. Second, the evaluation findings will help to provide public accountability regarding what German development cooperation has achieved in terms of strengthening SRHR.

Evaluation questions and methodology

The evaluation examined German development cooperation’s contributions to the strengthening of SRHR in partner countries in relation to each of the evaluation criteria. The evaluation questions (EQs) are structured in line with the evaluation criteria of the Organisation for Economic Co-operation and Development’s Development Assistance Committee (OECD DAC). The evaluation thus analysed the relevance, coherence, effectiveness, impact, efficiency and sustainability of German-supported SRHR interventions. The evaluation’s area of interest centres on the strengthening of SRHR in partner countries. It therefore focuses on interventions by bilateral official development cooperation. These interventions account for the largest share of funding that can be allocated to individual countries.

The evaluation is human rights-based, theory-based and method integration-based. First, it pursues the human rights-based evaluation (HRBE) approach. This applies human rights standards and principles to the object of the evaluation, the evaluation process and the methodology. Second, it pursues a theory-based approach in which assumptions formulated in a programme theory are examined empirically.

¹ These two tracks – the strengthening of SRH and of SRR – form the core of the approach for the area of intervention. With this approach, German development cooperation follows a holistic understanding of SRHR, as proposed by the Gutmacher-Lancet Commission (Starrs et al., 2018). It is assumed that the two tracks are interdependent. This means that neither track can generate impacts without the other track doing so too.

² <https://www.bmz.de/resource/blob/121222/our-development-policy-priorities-en.pdf>, accessed on 8 May 2025.

Third, it implements a method integration approach based on the combination of different methods.

All the evaluation questions were answered based on evaluation methods in which interventions already implemented in the area of intervention were analysed retrospectively.

The methods used varied according to the EQ: (1) In comparative case studies, interventions in partner countries selected on the basis of criteria were examined using in-person data collection (Malawi and Togo) or remote data collection (Guinea, Cameroon, Yemen and Kyrgyzstan). Data collection focused inter alia on interviews with rights-holders or their representative structures. (2) Furthermore, the findings of evaluations of SRHR projects implemented during the period covered by this evaluation (2011–2022) were subjected to content analysis, and analysed qualitatively and quantitatively. (3) In a secondary data analysis, data from the Demographic and Health Survey (DHS) and the Creditor Reporting System (CRS) of the OECD DAC were analysed statistically. (4) In addition, academic literature on the area of intervention was systematically analysed, visualised and evaluated using an evidence gap map (EGM).

Additionally, the evaluation identified future challenges for SRHR and used these to formulate recommendations.

As the recommendations are forward-looking and the answers to the EQs are mainly based on the analysis of interventions that have already been implemented, the scenario analysis method was applied in order to add a prospective dimension. Based inter alia on expert interviews, this method was used to identify possible future opportunities and challenges for strengthening SRHR in partner countries of German development cooperation.

Findings of the evaluation

Overall, SRHR interventions mostly achieve their intended impacts; however, there is a need for action to strengthen SRR and marginalised groups.

The interventions investigated often achieve their direct and indirect objectives. However, most interventions focus on strengthening SRH – such as improving the quality of healthcare services. They focus much less frequently on SRR. In particular, the sexual and reproductive autonomy of girls and women, or issues of their bodily integrity, are rarely addressed. Consequently, fewer impacts are achieved in these areas. Furthermore, people from economically or geographically marginalised groups, for example, in practice often still face barriers to accessing SRHR services and products. One reason for this may be that interventions rarely specify marginalised groups.

In the future, development cooperation will encounter a number of opportunities as well as challenges for strengthening SRHR.

This emerged from the scenario analysis, which identified possible scenarios for SRHR in 2035. This analysis reveals fundamental challenges for strengthening SRHR, such as a continued and deepening global polarisation and fragmentation with respect to SRHR. In many partner countries this might entail the restriction of fundamental rights. Economic inequalities and global crises – such as climate change and armed conflicts – could further increase the pressure on already weak healthcare systems. At the same time, the scenario analysis identifies future opportunities for strengthening SRHR. International alliances and certain civil society movements in partner countries might counter efforts directed against SRHR.

Table 1 Summary of findings

Criterion	Findings
Relevance	<p>The analysed interventions are partially aligned with SRH needs of rights-holders and barely aligned with their SRR needs. Gaps exist in particular with respect to sexual and reproductive autonomy and bodily integrity.</p> <ul style="list-style-type: none"> • Interventions in the area of intervention mostly fulfil needs of rights-holders, and address in particular the quality and accessibility of healthcare services. Needs with respect to the availability of SRH products, such as modern contraceptives, are partially addressed. • As regards SRR, interventions are barely aligned with the needs of rights-holders. While interventions focus partially on the information needs of rights-holders, significant gaps exist with regard to sexual and reproductive autonomy and bodily integrity. <p>The analysed interventions align with policy priorities of the partner country and the BMZ.</p> <ul style="list-style-type: none"> • Interventions in the area of intervention are fully aligned with the priorities of the partner country and the BMZ.
Coherence	<p>The analysed interventions use coordination mechanisms for external coherence mostly and for internal coherence partially.</p> <ul style="list-style-type: none"> • Interventions in the area of intervention mostly use coordination mechanisms with other development partners. Interventions of bilateral German development cooperation and those of other donors are coordinated when jointly implemented, such as in basket funding arrangements. • Formal mechanisms for coordination within bilateral German development cooperation exist only during the planning phase. These are used partially. During implementation, dialogue takes place only informally and ad hoc. Interventions are interlinked only sporadically. <p>Technical Cooperation (TC) and Financial Cooperation (FC) play mostly different roles in implementing the area of intervention.</p> <ul style="list-style-type: none"> • At a higher level, TC and FC interventions overall predominantly pursue objectives that can be categorised as SRH. To achieve these joint higher-level objectives they usually use different approaches.
Effectiveness	<p>The analysed interventions mostly fulfil their direct objectives with respect to SRH and SRR.</p> <ul style="list-style-type: none"> • The SRHR interventions mostly fulfil direct SRH-related objectives. They are effective in improving the quality and accessibility of healthcare services, increasing the availability of SRH products such as modern contraceptives, and creating enabling political environments. Given the small number of interventions, it is not possible to conclusively assess their contribution towards reducing financial barriers to access. • The interventions also mostly fulfil direct SRR-related objectives. This applies most frequently to objectives that involve attitudes of girls and women to SRR. Behavioural changes, changes in the environment of girls and women and changes in gender discriminatory attitudes are achieved less frequently.
Impact	<p>The analysed interventions mostly fulfil their indirect higher-level objectives; at national level, however, barely any impact of German development cooperation is evident.</p> <ul style="list-style-type: none"> • The interventions mostly fulfil their higher-level objectives with respect to SRH and SRR. However, a statistical correlation between the BMZ's ODA contributions and the objectives at the level of society as a whole can only be observed in the reduction of early pregnancies. • Only very few interventions contribute to a reduction in GBV and harmful practices and an improvement in gender equality.
Efficiency	<p>The analysed interventions fulfil their objectives partially efficiently.</p> <ul style="list-style-type: none"> • The interventions are rated as partially efficient, with production efficiency often playing a prominent role. In most cases insufficient information is available to support the rating of allocation efficiency.
Sustainability	<p>The positive intended effects of the analysed interventions are partially sustainable.</p> <ul style="list-style-type: none"> • The interventions are rated as partially sustainable. In particular, projects that are integrated into partner systems as closely as possible are rated as sustainable.

Conclusions and recommendations

Conclusion 1: Strengthening SRR and preparing gender-transformative change

While German development cooperation does contribute to strengthening SRH in partner countries, it only partially contributes to strengthening SRR and gender-transformative change. Bilateral development cooperation interventions often help to increase the quality, accessibility and availability of sexual and reproductive healthcare services and products. However, they make only a partial contribution towards changing values and norms relating to sexual and reproductive rights. For example, interventions barely address the needs of rights-holders as regards bodily, sexual and reproductive autonomy, equality and bodily integrity. To counteract this, DEval recommends implementing options for realising SRHR that depend on partner governments' interest in working together on SRR (recommendation 1), and defining standardised indicators for the holistic approach to SRHR (recommendation 2).

Recommendation 1: For each partner country in which the SRHR area of intervention is implemented through bilateral development cooperation, the BMZ – together with the implementing organisations – should develop context-specific options for action to strengthen SRHR. Here a distinction should be drawn between at least two types of partner countries: in countries with a strong interest in assuming responsibility for SRR alongside SRH, bilateral development cooperation should cover holistically all areas of activity within the SRHR area of intervention that relate to these partner countries. In countries with a correspondingly low level of interest, priority should first be given to creating an enabling framework for the holistic strengthening of SRHR. This will involve strengthening civil society actors and advising government partners.

Recommendation 2: Together with the implementing organisations, the BMZ should define standard indicators for the intended impacts of the holistic SRHR approach. These indicators should cover all fields of activity within the SRHR area of intervention that relate directly to impacts in partner countries. In particular, indicators should also be defined for the SRR-related field of activity. These indicators should be compiled in a catalogue and used by the implementing organisations when creating results matrices.

Conclusion 2: Strengthening marginalised groups

Formally, large marginalised groups – such as youth – are mostly addressed through activities in the SRHR area of intervention. However, the SRHR of these groups are only partially strengthened. For example, these groups still face barriers to accessing healthcare services. Furthermore, they are often not identified in interventions through disaggregation, and specific, smaller marginalised groups – such as LGBTI people or people with disabilities – are barely addressed at all as target groups in their own right. To counteract this, DEval recommends managing the strengthening of marginalised groups by including disaggregated indicators in the results matrices of interventions (recommendation 3). Additionally, the implementing organisations should continue refining evidence-based approaches to strengthening marginalised groups (recommendation 4).

Recommendation 3: The implementing organisations should ensure that results matrices of SRHR modules include disaggregated indicators for context-specific marginalised groups. This applies in particular to countries in which SRHR are strengthened holistically through bilateral development cooperation. When selecting indicators, the implementing organisations should incorporate the do-no-harm principle.

Recommendation 4: The implementing organisations should continue developing approaches to sustainably strengthen particularly marginalised groups, and pilot these in different partner country contexts on the basis of evidence. The starting point for this should be effective approaches for strengthening particularly marginalised groups identified in the evaluation and beyond.

Conclusion 3: The roles of TC and FC, and their coordination

When strengthening SRHR in partner countries, TC and FC mostly take on different roles. However, their interventions are rarely coordinated in order to achieve the higher-level objectives they share. This makes it difficult to implement the holistic approach that the BMZ requires for the SRHR area of intervention. Moreover, the allocation of roles is sometimes unclear. For example, separate TC and FC approaches are employed even though these do not match the respective BMZ profiles. To meet this requirement for holistic and integrated implementation and harness the potential of the complementary modules, DEval recommends implementing comprehensive development cooperation programmes, thus enabling TC and FC modules to interlock (recommendation 5).

Recommendation 5: In all partner countries where SRHR is implemented holistically, the BMZ and the implementing organisations should ensure that bilateral development cooperation modules for SRHR are interlinked and make a joint contribution towards long-term, higher-level objectives. To this end, they should in each case implement a development cooperation programme that encompasses all modules for the area of intervention. The programmes should define how the individual SRHR modules are interlinked such that their activities and impacts form a coherent whole in terms of content, place and time.

Conclusion 4: Context-specific use of effective, impactful and sustainable approaches

Some bilateral development cooperation approaches are more resistant to challenging contextual conditions in partner countries than others. In particular, the average effectiveness and impact of infrastructure interventions and

capacity development interventions is lower in countries with a lower Human Development Index (HDI) ranking and in fragile contexts than it is in other country contexts. By contrast, the effectiveness and impact of other approaches barely varies at all between country contexts. DEval therefore recommends a systematic and evidence-based analysis of the context-specific effectiveness, impactfulness and sustainability of specific approaches (recommendation 6).

Recommendation 6: The BMZ and the implementing organisations should continue developing the evidence-based use of approaches for SRHR by making structured use of existing databases containing evidence on the effectiveness and impact of these approaches. This includes both internal evidence from monitoring and evaluation as well as external evidence from scientific studies.

Conclusion 5: Strategic foresight in the area of intervention

Due to a variety of interactions with other sectors, the future environment for strengthening SRHR in partner countries is uncertain. In particular, a normative polarisation of attitudes towards SRHR and an increase in conflicts and climate change-induced disasters may pose challenges for strengthening SRHR in the future. Opportunities for the future development of SRHR will arise from the digitalisation of healthcare and from strong civil society actors who are committed to SRHR. To be able to respond to these and other future challenges, DEval recommends engaging with them and building preparedness before they materialise (recommendation 7).

Recommendation 7: The BMZ should further refine the strategic foresight processes implemented in the past, such as those expressed in the “Development Policy 2032” study, and regularly continue them at cross-sectoral level. This will enable the systematic analysis of future opportunities and challenges for development policy, and the preparation of responses to them. The outcomes of this process and the findings of the scenario analysis should be used for future strategic management of the SRHR area of intervention.

CONTENT

Imprint	iv	4.2	Coherence	33	
Acknowledgements	v	4.2.1	External and internal coherence	33	
Executive summary	vii	4.2.2	The roles of TC and FC	35	
Abbreviations and acronyms	xiv	4.3	Effectiveness	38	
Glossary	xvi	4.3.1	Achievement of direct objectives	38	
		4.3.2	Factors influencing the achievement of direct objectives	45	
1. Background and aims of the evaluation	1	4.4	Impact	49	
		4.5	Efficiency	56	
2. Object of the evaluation – the SRHR area of intervention	3	4.6	Sustainability	59	
		5. Findings II: SRHR in the year 2035	62		
2.1	Defining SRHR	4			
2.2	Strategic foundations for SRHR	6	6. Conclusions and recommendations	69	
2.3	Intended effects on SRHR in partner countries	7			
2.4	Implementing the SRHR area of intervention	10	6.1	Strengthening SRR and preparing gender-transformative change	70
			6.2	Strengthening marginalised groups	74
3. Evaluation questions and methods	13		6.3	The roles of TC and FC, and their coordination	78
			6.4	Context-specific use of sustainable, effective and impactful approaches	81
3.1	Evaluation questions and assessment criteria	14	6.5	Strategic foresight in the area of intervention	84
3.2	Design of the evaluation	15	7. Literature	86	
3.3	Methods of the evaluation	16			
3.3.1	Retrospective methods	16	8. Annex	97	
3.3.2	Prospective method	18			
3.4	Reflections on the methodology	19	8.1	Rating scale for DEval evaluations	98
			8.2	Evaluation matrix	99
4. Findings I: implementation of the area of intervention	20		8.3	Timeline of the evaluation	104
			8.4	Evaluation team and contributors	105
4.1	Relevance	23			
4.1.1	Alignment with rights-holders' needs	23			
4.1.2	Alignment with policies and priorities of partners and German development cooperation	31			

Figures

Figure 1	Results framework for the SRHR area of intervention	8
Figure 2	ODA disbursements by the BMZ for SRHR 2011–2022 (absolute and relative)	11
Figure 3	ODA disbursements by the BMZ for SRHR by channel 2011–2022 (absolute)	11
Figure 4	Overview of the rating of evaluation questions and assessment criteria (part 1)	21
Figure 5	Overview of the rating of evaluation questions and assessment criteria (part 2)	22
Figure 6	Alignment of interventions with SRH needs of rights-holders (AC 1)	25
Figure 7	Alignment of interventions with SRR needs of rights-holders (AC 2)	26
Figure 8	Alignment of intervention objectives with policies and priorities of German development cooperation (AC 1)	31
Figure 9	Alignment of intervention objectives with policies and priorities of partner countries (AC 2)	32
Figure 10	Approaches used by SRHR interventions	37
Figure 11	Achievement of direct objectives related to SRH (EQ 3.2, AC 1)	39
Figure 12	Achievement of direct objectives related to counselling (EQ 3.3, AC 1)	40
Figure 13	Achievement of direct objectives related to SRR (EQ 3.3, AC 2)	41
Figure 14	Enabling and constraining factors influencing the achievement of direct objectives	46
Figure 15	Achievement of higher-level targets for the strengthening of self-determination (AC 1)	51
Figure 16	Findings of the multivariate regression analysis on the relationship between BMZ ODA disbursements for SRHR and SRHR target indicators for data from 2011 to 2022	54
Figure 17	Achievement of higher-level targets for the strengthening of the right to SRH (AC 3)	55
Figure 18	Findings of the multivariate regression analysis on the relationship between BMZ disbursements for SRHR and the SRHR target indicator “early pregnancy/motherhood” for data from 2011 to 2022	56

Figure 19	Rating of the efficiency of the interventions overall (AC 1)	57
Figure 20	Rating of the production efficiency of the interventions (AC 2, indicator 2.1)	58
Figure 21	Rating of the sustainability of the interventions overall (AC 1)	60
Figure 22	Rating of the sustainability by approaches and HDI of the partner countries	61
Figure 23	The funnel of the future and space of possibility for potential SRHR scenarios	64

Tables

Table 1	Summary of findings	ix
Table 2	Rating scale and aspiration level	98

Boxes

Box 1	Sexual and reproductive health and rights and feminist development policy	6
Box 2	Excursus – Fundamentals of the programme theory for the evaluation	7
Box 3	Operationalising sexual and reproductive health and rights	10
Box 4	Voices of rights-holders – respectful and culturally appropriate obstetric care	28
Box 5	Voices of rights-holders – people with disabilities	30
Box 6	Voices of rights-holders – gender transformation and the role of men	42
Box 7	Voices of rights-holders – youth-friendly services	43
Box 8	Voices of rights-holders – strengthening the self-determination of girls	51
Box 9	Voices of rights-holders – gender-based violence	52
Box 10	Contributions to the 2030 Agenda for Sustainable Development	75

ABBREVIATIONS AND ACRONYMS

AC <i>Assessment criterion</i>	DEVAW <i>Declaration on the Elimination of Violence Against Women</i>	GBV <i>Gender-based violence</i>	IDOS <i>German Institute of Development and Sustainability</i>
BMZ <i>German Federal Ministry for Economic Cooperation and Development</i>	DHS <i>Demographic and Health Survey</i>	GDP <i>Gross domestic product</i>	IPPF <i>International Planned Parenthood Federation</i>
CEDAW <i>Convention on the Elimination of all Forms of Discrimination against Women</i>	DIMR <i>German Institute for Human Rights</i>	GFF <i>Global Financing Facility for Women, Children and Adolescents</i>	IRC <i>International Rescue Committee</i>
CEMAC <i>Communauté Économique et Monétaire de l'Afrique Centrale (Economic and Monetary Community of Central Africa)</i>	DSW <i>Deutsche Stiftung Weltbevölkerung (German Foundation for World Population)</i>	GII <i>Gender Inequality Index</i>	KfW <i>KfW Development Bank</i>
CESCR <i>Committee on Economic, Social and Cultural Rights</i>	ECOWAS <i>Economic Community of West African States</i>	GIZ <i>Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH</i>	LDCs <i>Least developed countries</i>
CRC <i>Convention on the Rights of the Child</i>	EGM <i>Evidence gap map</i>	HDI <i>Human Development Index</i>	LGBTI <i>Lesbian, gay, bisexual, transgender and intersex</i>
CRS <i>Creditor Reporting System</i>	EU <i>European Union</i>	HIPs <i>High-impact practices</i>	MDG <i>Millennium Development Goal</i>
CSE <i>Comprehensive Sexuality Education</i>	FC <i>Financial Cooperation</i>	HIV/AIDS <i>Human immunodeficiency virus/acquired immunodeficiency syndrome</i>	MICS <i>Multiple Indicator Cluster Survey</i>
DAC <i>Development Assistance Committee (of the OECD)</i>	FCDO <i>Foreign, Commonwealth and Development Office (of the United Kingdom)</i>	HRBE <i>Human rights-based evaluation</i>	MMR <i>Maternal mortality ratio</i>
	FE <i>Fixed effects</i>	ID <i>Identification</i>	NGO <i>Non-governmental organisation</i>
	FGM <i>Female genital mutilation</i>	ICESCR <i>International Covenant on Economic, Social and Cultural Rights</i>	ODA <i>Official development assistance</i>
			OECD <i>Organisation for Economic Co-operation and Development</i>

OHCHR

*Office of the High Commissioner
for Human Rights*

SDG

Sustainable Development Goal

SRH

Sexual and reproductive health

SRHR

*Sexual and reproductive
health and rights*

SRR

Sexual and reproductive rights

STIs

Sexually transmitted infections

TC

Technical Cooperation

UHC

Universal health coverage

UN

United Nations

UNDP

*United Nations
Development Programme*

UNEG

United Nations Evaluation Group

UNFPA

United Nations Population Fund

UNGA

United Nations General Assembly

UNHCR

*United Nations High
Commissioner for Refugees*

UNICEF

United Nations Children's Fund

WHO

World Health Organization

GLOSSARY

Gender sensitivity

The term “gender sensitivity” refers to the appreciation and consideration of different life situations and conditions of people of different genders. This includes an awareness of gender-specific role models and of how gender is perceived and judged. Gender-sensitive evaluations focus on the consideration of societal gender roles and gender-specific inequalities in a society, with particular reference to the role of girls and women. Gender sensitivity is implemented in evaluations at the process and content level, for instance with regard to health, social or methodological aspects.

Gender-transformative approaches

In development cooperation, gender inequalities are addressed *inter alia* through gender-transformative approaches. These approaches aim to challenge and break down discriminatory laws and power structures, social norms and attitudes, as well as gender-stereotypical roles (BMZ, 2023a, 2023d, 2023e). They are thus designed to help change societal awareness and, in the long term, bring about social change. Gender-transformative approaches encompass the individual, interpersonal, societal and political levels. Examples include dialogues with duty-bearers and structurally marginalised groups, or educational interventions on gender forms and the topic of sexual and reproductive health and rights (SRHR) in schools. Gender sensitivity represents the basis for gender transformation (see also the glossary entry on “Gender sensitivity”).

Multiple discrimination and intersectionality

Multiple discrimination denotes a form of discrimination whereby people are affected by structural marginalisation based on several overlapping socio-demographic characteristics and social categories (see also the glossary entry on “Structurally marginalised groups”). These include groups such as women with disabilities or lesbian, gay, bisexual, transgender and intersex (LGBTI) people who are also members of an ethnic minority. Intersectionality denotes the interaction of several grounds of discrimination that are inextricably and mutually linked in a particular context and that place a person at a greater disadvantage than others in the same situation. The concept of “intersectionality” was coined by the American lawyer Kimberlé Crenshaw, who used the image of a traffic intersection to illustrate the intersection of different social categories (Crenshaw, 1989, 1991). An intersectional perspective makes it possible to analyse these interrelationships and explain the associated forms of discrimination.

Rights-holders and duty-bearers

From a human rights perspective, the term “rights-holders” refers to all persons who possess human rights. Rights-holders are legally entitled to have their rights fulfilled by “duty-bearers”. Duty-bearers are institutions and actors who have a particular obligation to respect, protect and fulfil human rights. The relationship between the two parties is thus structured as follows: rights-holders are always regarded as such in relation to duty-bearers, and vice versa. In the context of the evaluation, rights-holders are the people who live in the partner countries.

The evaluation uses the term “directly addressed rights-holders” when referring to explicitly designated target persons or target groups of development cooperation interventions that have participated in the activities of the intervention. The term “duty-bearers” is usually used for state actors, but non-state actors can also be duty-bearers and can be held accountable for actions or omissions that affect human rights. The evaluation follows the example of the United Nations Evaluation Group (UNEG) in using the term “primary duty-bearers” for states and state institutions (in the partner countries or in Germany), and the term “secondary duty-bearers” for private individuals (such as parents) and for private companies, which may be subject to duty of care obligations towards third parties (such as minors or workers) (UNEG, 2014). Following the BMZ’s human rights strategy, this evaluation, as a human rights-based evaluation, adopts a different perspective and primarily uses the terms “rights-holders” and “duty bearers” (BMZ, 2011).

Right to education and information in connection with sexuality and reproduction

Managing sexual and reproductive issues on a self-determined basis requires appropriate knowledge. Educational programmes have a positive impact inter alia on girls' and women's knowledge on SRHR, and strengthen their rights and participation. For example, the United Nations (UN) conventions on women's and children's rights oblige their state parties to realise the right of all rights-holders to education and information in connection with sexuality and reproduction. The UN Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) calls for equal rights for women in education on health and family planning-related matters, as well as access to information. It also takes into account the special needs and problems of women in rural areas and the elimination of stereotypical views of the roles of men and women. The UN Convention on the Rights of the Child (CRC) requires states parties to ensure the right to education by providing information on family planning.

Right to health, including SRH

A guaranteed right to health, including sexual and reproductive health, is a fundamental human right. The Universal Declaration of Human Rights guarantees all people the right to a standard of living adequate for health and well-being. The right to sexual and reproductive health is also enshrined in various human rights conventions. In the International Covenant on Economic, Social and Cultural Rights (ICESCR), states undertake to realise the right of all rights-holders to the enjoyment of the highest attainable standard of physical and mental health. This includes steps to reduce stillbirths and infant mortality, to ensure the healthy development of the child and to provide medical care in the event of sickness. Special attention is paid to the health-related rights of women in the CEDAW. The corresponding rights of children are set out in the CRC.

Right to bodily integrity, including safety from GBV and harmful practices

The Universal Declaration of Human Rights stipulates that no human being shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. The right to bodily integrity contained therein, including safety from gender-based violence (GBV) and harmful practices, is also enshrined in other human rights conventions and resolutions. The UN Declaration on the Elimination of Violence Against Women defines this form of violence as physical, sexual and psychological violence experienced by women in partnerships/marriages, in the family, in the community, or perpetrated or condoned by the state. States parties are called upon to prevent, combat and punish violence against women and girls and to offer protection and redress to those affected. The UN Convention on the Rights of Women also deals with the protection of women and girls and obliges states parties to take steps to abolish practices such as human trafficking, prostitution and child marriage. The UN Convention on the Rights of the Child places a special focus on minors, which deals with the protection of children from violence, abuse and exploitation, among other things. It calls on the states parties to take preventive steps and support those affected.

Sexual and reproductive health and rights

Sexual and reproductive health and rights (SRHR) are enshrined in human rights and are a core component of the 2030 Agenda for Sustainable Development. The evaluation is based on the new definition of the Guttmacher-Lancet Commission (Starrs et al., 2018). According to this definition, sexual and reproductive health (SRH) encompasses "physical, emotional, mental and social wellbeing in relation to all aspects of sexuality and reproduction", and thus goes beyond the absence of disease or the dysfunction of reproductive organs (Starrs et al., 2018, p. 4). SRH is determined by the availability, implementation and fulfilment of sexual and reproductive rights (SRR). SRR include "the right to control one's own body, define one's sexuality [or gender identity], choose one's partner, and receive confidential, respectful, and high-quality [healthcare] services" (Starrs et al., 2018, p. 1), and this for "all individuals [...] free from discrimination, coercion and violence" (Starrs et al., 2018, p. 4).

Strategic foresight

Strategic foresight is a method for systematically researching and analysing possible futures, and represents a practical, strategically oriented sub-area of futurology. While futurology focuses primarily on the scientific understanding of long-term developments, strategic foresight uses these findings to obtain targeted recommendations for the present and the near future. The focus of strategic foresight is on identifying potential risks at an early stage and recognising opportunities in order to support strategic decisions.

Strategic foresight is interdisciplinary, and integrates findings from various fields such as science, technology, business, politics and society. Experts and other stakeholders from various fields are involved in the process in order to ensure a broad range of perspectives.

Structurally marginalised groups

The BMZ defines structurally marginalised groups as people who are treated unequally, oppressed or marginalised due to various attributes such as gender, origin, ethnicity, age, disability, socio-economic status, gender identity, sexual orientation or religion/worldview (BMZ, 2023a, 2023d). This evaluation follows that understanding. The term “group” is not used to describe a context-specific social minority. Rather, it is used to describe people who display (one or more) socio-demographic attributes or social categories, on the grounds of which they experience structural marginalisation disadvantage. The grounds for structural marginalisation vary depending on the context.

1.

BACKGROUND AND AIMS OF THE EVALUATION

Strengthening sexual and reproductive health and rights (SRHR) is a global task. Despite some successes in reducing maternal and neonatal mortality, as well as unintended and early pregnancies and gender-based violence (GBV), people's SRHR are still restricted in many places. Worldwide, complications resulting from pregnancy and birth are one of the main causes of mortality in girls aged between 15 and 19 (OHCHR, 2020a). It is also estimated that almost half of all pregnancy terminations are unsafe (UNFPA, 2022a). During the COVID-19 pandemic, an increase in GBV was also evident (Massay et al., 2022; UNFPA, 2021a). Furthermore, sexual and reproductive rights – especially those of women, girls and marginalised groups such as LGBTI people – remain very limited in many of German development cooperation's partner countries (BMZ, 2023b; UNFPA, 2021a).

Through its area of intervention “Population dynamics; sexual and reproductive health and rights”, Germany's Federal Ministry for Economic Cooperation and Development (BMZ) is working together with its partners to improve SRHR. Development cooperation interventions in partner countries aim to improve the quality and accessibility of sexual and reproductive health (SRH) services and to realise the sexual and reproductive rights (SRR) of girls and women and other marginalised groups more extensively (BMZ, 2023b).

Germany is one of the key bilateral actors for the promotion of SRHR (DSW, 2023). So far, the BMZ has committed around 100 million euros annually to the Initiative on Rights-based Family Planning and Reproductive Health for All, which brings together the ministry's SRHR programmes.³

SRHR are of strategic and political importance to the BMZ. At the time of the evaluation, strengthening SRHR was included among the BMZ's development policy priority areas. This is illustrated for instance by the overlaps between goals of the SRHR intervention area and those of the feminist development policy (BMZ, 2023a).⁴ Furthermore, the Coalition Agreement of the German Federal Government elected in 2025 emphasises SRHR as an important area of development policy (German Federal Government, 2025). The importance of the area of intervention can also be traced back to interactions with a large number of other development cooperation sectors. For example, the BMZ assumes that SRHR has spillover effects on employment promotion and sustainable economic development in partner countries. It also links the areas of education, social protection, general healthcare and good governance with SRHR (BMZ, 2023b).

Given this significance of the SRHR area of intervention for development policy, the present DEval evaluation pursues two goals:

- **Enable learning:** The evaluation is designed to support further development of the SRHR area of intervention in German development cooperation. Its findings should supply information on which interventions and approaches have been successful to date, and how the area of intervention and activities within it can be improved. It is thus designed to make German development cooperation more effective in strengthening SRHR in its partner countries. The evaluation can also suggest how core elements of the feminist development policy, such as the gender-transformative approach, can be implemented.
- **Provide accountability:** The evaluation has comprehensively analysed and assessed the implementation of interventions to strengthen SRHR to date. By reporting transparently on successes and failures, it can help provide public accountability on German development cooperation's strengthening of SRHR in partner countries.

³ <https://www.bmz.de/en/issues/bodily-autonomy-and-reproductive-health>, accessed on 12 December 2024.

⁴ <https://www.bmz.de/resource/blob/121222/our-development-policy-priorities-en.pdf>, accessed on 6 December 2023.

2.

**OBJECT OF THE EVALUATION
– THE SRHR AREA OF
INTERVENTION**

The object of this evaluation is Germany's development-policy engagement to strengthen SRHR in partner countries.

The overarching framework for this engagement is provided by the area of intervention “Population dynamics; sexual and reproductive health and rights”. This encompasses bilateral and multilateral contributions, civil society contributions and development-policy interventions.

The present evaluation focuses on development cooperation interventions that can be assigned to specific countries.

As these are mainly interventions of official implementing organisations, the evaluation focuses on bilateral, official development cooperation (see Section 2.4).⁵

The evaluation examines Germany's engagement for SRHR during the period from 2011 to 2022. Since 2011, German contributions to the G8 Muskoka Initiative on Maternal, Newborn and Child Health have been brought together under the BMZ Initiative on Rights-based Family Planning and Reproductive Health for All. These largely match those interventions that are assigned to the area of intervention for the present evaluation.⁶ The evaluation therefore focuses on the period from 2011 onwards (BMZ, 2022).

2.1 Defining SRHR

SRHR encompasses sexual and reproductive health, as well as an individual's right to make autonomous decisions about their own body, sexuality and reproduction that are free from discrimination, stigma, coercion and violence.

The Gutmacher-Lancet Commission proposes a holistic and human rights-based understanding of SRHR (Starrs et al., 2018).⁷ According to this understanding, the term “SRHR” includes a sexual and reproductive health (SRH) component. This concerns people's bodily, emotional, mental and social well-being in relation to all elements of sexuality and reproduction. The term also includes a sexual and reproductive rights (SRR) component. This encompasses people's right to make autonomous decisions concerning their own body, sexuality and gender identity, and concerning partner selection, marriage and reproduction. It also includes their right to non-discriminatory access to confidential, respectful and high-quality services, information and products. These two components interact and are interdependent: for example, gender-discriminatory social norms and attitudes often hinder the strengthening of SRHR, especially those of marginalised groups (Starrs et al., 2018; UNFPA, 2021a, 2024a).⁸

⁵ The term “bilateral development cooperation” refers to “direct, contractually agreed development cooperation between Germany and a partner country” (<https://www.bmz.de/de/service/lexikon#lexicon=14098>, accessed on 19 November 2024). Corresponding funds are implemented mainly by official implementing organisations. As described in Section 2.4, most of the BMZ's financial contributions that are implemented through multilateral channels cannot be assigned to specific countries. BMZ funds that are implemented through civil society channels account for a very small share of all SRHR-related financial contributions, hence these are also not included.

⁶ During this period the title of the initiative was changed several times. The initiative aims to improve access to rights-based family planning, safe births and the training of health specialists in partner countries (BMZ, 2022, 2023b). In the evaluation, both interventions that are brought together under the initiative and other interventions to promote SRHR, such as interventions to end violence against women and girls or interventions on population dynamics and statistics, are assigned to the area of intervention (see Section 2.3 and Section 2.4, Box 3).

⁷ From 2016 to 2018, leading experts in the Gutmacher-Lancet Commission worked on the development of a comprehensive and evidence-based agenda to strengthen sexual and reproductive health and rights. See <https://www.gutmacher.org/gutmacher-lancet-commission>, accessed on 16 September 2024.

⁸ This applies particularly to people who experience intersectional disadvantage. An overview of groups facing particular disadvantage in the context of SRHR can be found in the online annex.

To guarantee SRHR, people need access to essential services that meet human rights and health standards.⁹

These services include effective and safe contraceptives, the prevention and treatment of sexually transmitted infections (STIs), and prenatal, perinatal and postnatal care. They also include comprehensive sexuality education (CSE), access to safe pregnancy terminations, the prevention and detection of and counselling on GBV including harmful practices¹⁰, the prevention, detection and treatment of cancers of the reproductive organs, and counselling on and/or treatment of sexual (dys)function and satisfaction (Starrs et al., 2018).

SRHR are enshrined in human rights law. International and regional¹¹ human rights treaties contain numerous references to SRHR (an overview table can be found in the online annex). For instance, the right to health, as described in the International Covenant on Economic, Social and Cultural Rights, includes the right to SRH. This right to SRH in turn includes bodily autonomy and non-discriminatory access to services, products and information for all (CESCR, 2016). It is thus linked to the right to non-discrimination. The right to bodily integrity also entails unrestricted access to reproductive services, including safe pregnancy terminations¹² (OHCHR, 2020c).

This includes the right to comprehensive, age-appropriate, non-discriminatory and evidence-based sexuality education and the right to autonomous decision-making on the number and spacing of children (CESCR, 2016; OHCHR, 2020d). Protection against GBV and harmful practices is also enshrined in human rights law. GBV and harmful practices are human rights violations, and threaten inter alia the right to SRH, autonomy and bodily integrity (OHCHR, 2020b).

SRHR are a core component of the 2030 Agenda for Sustainable Development. . The 2030 Agenda enshrines them in several Sustainable Development Goals (SDGs) (see also Box 10 in Section 6.2).¹³ Direct links can be found in the targets for SDG 3 on good health and well-being. These envisage reducing maternal and neonatal mortality (targets 3.1 and 3.2) and ensuring access to sexual and reproductive healthcare services (target 3.7).¹⁴ Elements of SRHR can also be found in other SDGs in the 2030 Agenda. For example, SDG 5 on gender equality includes explicit SRHR targets. These include ending discrimination against girls and women (target 5.1), eliminating violence against girls and women (target 5.2) end eliminating so-called harmful practices such as female genital mutilation (FGM) (target 5.3). Ensuring universal access to SRH and SRR is also explicitly specified (target 5.6; UNGA, 2015).

⁹ This means that healthcare facilities, services, information and products must be available, as well as non-discriminatory, and financially and physically accessible. They must also be culturally and medico- ethically appropriate, gender- and age-appropriate, and confidential and respectful (in other words, acceptable). Healthcare services, information and products must be of high quality, scientifically and medically appropriate, evidence-based and delivered by trained personnel (CESCR, 2000).

¹⁰ The German Institute for Human Rights (DIMR) defines GBV as “[...] violence directed against a person because of their biological sex or social gender”, and includes physical, sexualised, psychological and economic violence in private and public spaces (see <https://www.institut-fuer-menschenrechte.de/themen/geschlechtsspezifische-gewalt>, accessed on 12 December 2024). The Declaration on the Elimination of Violence Against Women (DEVAW) states that GBV includes harmful practices. Among other things, female genital mutilation (FGM), child and forced marriage, virginity testing, incest, violent initiation rites and widowhood practices are designated as harmful practices (OHCHR, 2020b). For the sake of clarity, the term “GBV and harmful practices” is used throughout this report, even though GBV is the umbrella term and subsumes “harmful practices”. This is in order to underline the fact that the report also gives consideration to the most serious human rights violations in the context of GBV.

¹¹ In the African context, for example, these include the African Charter on Human and Peoples' Rights, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) and the Addis Ababa Declaration on Population and Development in Africa beyond 2014..

¹² As part of their right to health, women are entitled to services that reduce maternal mortality, including access to skilled birth attendance, post-partum care, safe pregnancy terminations and other SRH services. The denial of safe terminations and coercion to continue a pregnancy are also described as GBV (OHCHR, 2020c).

¹³ The Millennium Development Goals (MDGs) initially did not integrate elements of SRHR, despite the fact that some of these elements were recognised as human rights following the 1994 World Population Conference (Haslegrave, 2013). The MDGs did not include such a goal until 2007. However, this was limited to universal access to reproductive health (Starrs et al., 2018).

¹⁴ SSDG 3 also targets universal health coverage (UHC). This means that all people should have access to the quality healthcare services they need throughout their lives, without having to face financial hardship as a result. UHC encompasses basic services including prevention, treatment and rehabilitation (see <https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-uhc>, accessed on 12 December 2024). These two targets of SDG 3 are interdependent. UHC cannot be achieved unless essential SRHR services of sufficient quality are accessible to all rights-holders without financial risk.

2.2 Strategic foundations for SRHR

The BMZ follows the internationally recognised definition of SRHR. The area of intervention “Population dynamics; sexual and reproductive health and rights” forms part of the BMZ core area 6 “Health, social protection and population dynamics”. The BMZ core area strategy formulates four areas of activity through which German development cooperation is to strengthen SRHR and sustainable population dynamics (BMZ, 2023b): (1) SRH, (2) SRR, (3) population dynamics and the improved use of population data, and (4) international cooperation to support the promotion of SRHR. The BMZ thus follows the internationally recognised holistic definition of SRHR that includes both SRH and SRR.

The current strategy for the area of intervention continues several previous strategies that already included core elements of the holistic understanding of SRHR. From 2008, the BMZ position paper on SRHR and population dynamics formed the basis for addressing these two areas (BMZ, 2008). In the paper, the BMZ underlines the importance of a human rights-based approach as the foundation for SRHR. In this context it

also mentions contributions to non-discriminatory access to services, information and contraceptives, as well as the ending of GBV and the elimination of gender-based discrimination. It also mentions the importance of involving men and male youth (BMZ, 2008). In 2014 the position paper was supplemented by strategic guidelines for German development cooperation in the area of population dynamics. Here too, the BMZ underlines autonomy and human rights as key elements of interventions in the area of population dynamics (BMZ, 2014).

SRHR is a core component of Germany's current development-policy agenda. When the evaluation was carried out, the BMZ's current priorities included direct and indirect references to SRHR.¹⁵ The strategy for feminist development policy, for example, references SRHR multiple times (see Box 1 and BMZ, 2023a). Furthermore, SRHR is also mentioned in the Action Plans on Gender Equality (BMZ, 2009, 2016, 2023e), the Action Plan Agents of Change – Children and Youth Rights in German Development Cooperation Activities (BMZ, 2017), the Position Paper Global Health – An Investment in the Future (BMZ, 2019), the Strategy Paper Development Policy 2030 (BMZ, 2018a) and the BMZ's Africa Strategy (BMZ, 2023f).

Box 1 Sexual and reproductive health and rights and feminist development policy

The BMZ strategy for feminist development policy contains multiple references to sexual and reproductive health and rights. The strategy formulates the goal of strengthening rights and self-determination and eliminating discriminatory power structures. Interventions to promote sexual and reproductive health and rights are used as examples to show how women and marginalised groups can be strengthened, and measures taken that “specifically aim to eliminate discriminatory norms and structures, gender roles and stereotypes” (BMZ, 2023a). The sexual and reproductive health and rights area of intervention is also especially important for realising rights, access to resources and the representation of women and marginalised groups. Besides eliminating barriers that prevent rights-holders from knowing and claiming their sexual and reproductive rights, and strengthening the right to sexual and reproductive health, a feminist development policy should also prevent gender-based violence and harmful practices (BMZ, 2023a). The intersectional perspective¹⁶ and the expansion of gender-transformative approaches are also part of the strategy.

¹⁵ Besides the direct links to SRHR in the priority area “Providing global health and bodily autonomy”, there are also indirect links in the priority area “Embracing a feminist development policy” (see <https://www.bmz.de/resource/blob/121224/schwerpunkte-unserer-entwicklungspolitik-de.pdf>, accessed on 26 August 2024).

¹⁶ The strategy for a feminist development policy describes an intersectional perspective as one that considers the interplay between different dimensions of inequality and grounds of discrimination, and focuses on groups that experience multiple forms of discrimination (see <https://www.bmz.de/de/aktuelles/dialog-sexuelle-und-reproduktive-gesundheit-und-rechte-153190>, accessed on 12 December 2024).

2.3 Intended effects on SRHR in partner countries

German development cooperation in partner countries should strengthen the sexual and reproductive health and rights of women and young people in all their diversity and thus also contribute to gender equality and sustainable population dynamics. According to the BMZ strategy for the area of intervention, German development cooperation in partner countries should improve the SRH of girls and women, thus reducing maternal and neonatal mortality as well as unintended and early pregnancies (BMZ, 2023b). It should also

empower rights-holders to claim and exercise their SRR. This should focus on girls and women and young people in all their diversity. Accordingly, LGBTI people should also be empowered (see also The Federal Government, 2021).¹⁷ Specific higher-level effects are the strengthening of girls' and women's bodily autonomy and the reduction of GBV and harmful practices. At a higher level, this should also contribute to the transformation of gender roles and strengthen gender equality in partner countries. Furthermore, development cooperation should also contribute to a more enabling environment for a demographic dividend¹⁸ (siehe Figure 1).

Box 2 Excursus – Fundamentals of the programme theory for the evaluation

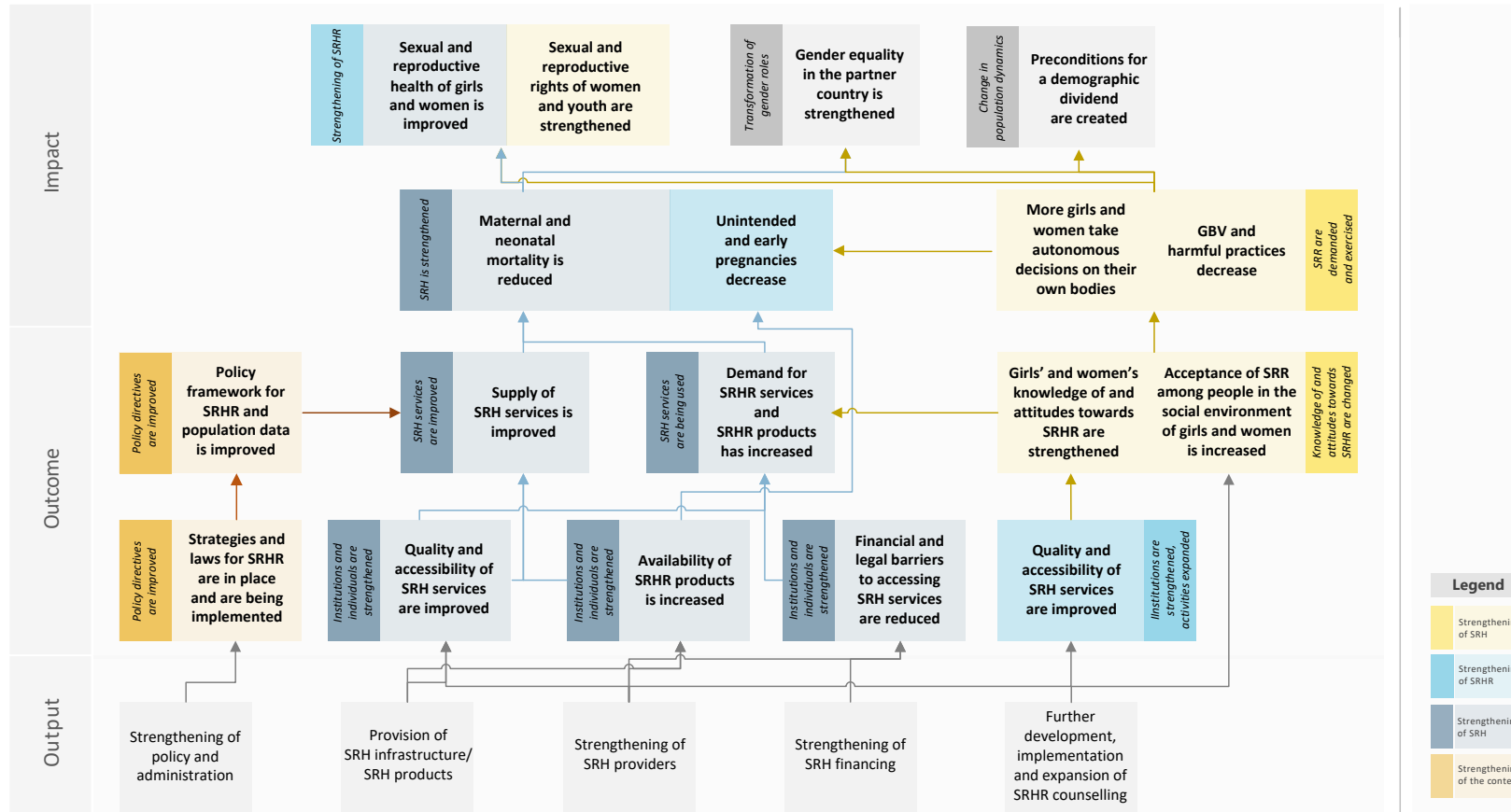
Programme theories form the basis for the empirical analysis and assessment of evaluation objects and are often visualised as a results framework. In this evaluation, the programme theory contains the BMZ's assumptions concerning higher-level results for the sexual and reproductive health and rights area of intervention and information on corresponding development cooperation activities. The programme theory is based on the BMZ strategy for the area of intervention. As the strategy contains little detailed information on specific activities of development cooperation interventions, additional programme documents of selected interventions were used to formulate the theory and thus gain a clearer overall picture of activities. These assumptions concerning results were also supplemented with findings of scientific studies.¹⁹

¹⁷ A special focus should be placed on people from marginalised groups. Since women and young people are groups whose experience of disadvantage can be compounded and exacerbated by other factors, development cooperation should pay particular attention to intersectionality (see online annex). To strengthen SRHR, men and both female and male authorities should also be included in interventions.

¹⁸ The core area strategy describes a demographic dividend as the age structure shifts in favour of the working population (BMZ, 2023a).

¹⁹ This was based on the draft core area strategy for the BMZ's core area 6 (BMZ, 2023b) and the draft Theory of Change for the initiative area SRHR (doc xxvi [non-public documents are cited using pseudonyms]). In addition, the "Population dynamics in German development cooperation" handbook was consulted (GIZ, 2018). Also consulted were summaries of intervention types implemented in the area of intervention, such as public materials, and internal evaluations by the implementing organisations (see also Gade and Gabriel, 2021; doc xiv; doc xv). Furthermore, planning documents of interventions in partner countries where SRHR is a priority as part of the core area, or which are implemented through bilateral development cooperation, were analysed. The comparison with scientific studies enabled the evaluation team to supplement the strategic assumptions concerning results where gaps existed, and thus map the object of the evaluation completely and correctly. The approach also enabled the team to identify causal mechanisms for specific tracks (Christie and Lemire, 2019; Gasteiger et al., 2021).

Figure 1 Results framework for the SRHR area of intervention



Source: DEval's own graphic. The graphic does not show contextual factors that play an important role for the effectiveness and impact of interventions (see online annex).

Impacts on SRHR are to be achieved via three tracks²⁰ each of which includes separate impacts; these higher-level impacts are, however, interdependent:

1. Strengthening state frameworks for SRHR:

At national level, development cooperation should contribute to the formulation of policy directives for SRHR, and support their implementation at the national, regional and local levels of administration. This should create enabling frameworks for strengthening SRHR and contribute to the support of sustainable population dynamics.²¹ It is assumed that impacts in this track are among the prerequisites for changes in the other tracks.

2. Strengthening SRH:

By contributing to an increase in the supply of SRH services and a corresponding increase in demand, development cooperation aims to reduce maternal and neonatal mortality and prevent unintended and early pregnancies. To achieve this, development cooperation interventions should first of all strengthen healthcare facilities and the related infrastructure, thereby improving the quality and accessibility of SRH services.²² Second, development cooperation should increase the availability

of SRH products (e.g. medicines or contraceptives) by expanding supply chains.²³ To increase demand for SRH services, development cooperation should remove legal and financial barriers to accessing SRH services.²⁴

3. Strengthening SRR:

By contributing to the development of knowledge and attitudinal changes among girls and women, as well as people in their environment, development cooperation should enable girls and women to make more autonomous decisions about their own bodies. At a higher level, the aim is to prevent unintended and early pregnancies as well as GBV and harmful practices. These results should be achieved by improving the quality and accessibility of counselling and awareness-raising measures and by strengthening providers of such services.²⁵ In conjunction with counselling and awareness-raising, the aim is to increase knowledge about SRHR and change attitudes – among girls and women as well as in their environment, for example among young men or traditional authorities.²⁶ This is a prerequisite for breaking down social barriers to accessing SRH services, and thus increasing the demand for such services. It is assumed that the effects of the second track cannot be achieved without this third track.

²⁰ Three of the four areas of activity covered by the area of intervention are relevant to strengthening SRHR in partner countries (see Figure 1; BMZ, 2023b). “International cooperation” is of indirect importance. This relates mainly to the BMZ’s political work, as well as contributions to multilateral and international organisations that are not managed by the BMZ on a country-specific basis.

²¹ Bilateral development cooperation interventions aim, for instance, to set quality standards for SRH services at national level, to strengthen local authorities in order to improve support for healthcare facilities, or to create frameworks for the use of population data for policy decisions. Effects at the level of policy frameworks were analysed in scientific studies, among others by Uzoichukwu et al. (2020). This study looked at an intervention promoting various advocacy organisations and individuals from civil society and the media, in order to mainstream maternal and neonatal health as an issue in the political debate.

²² For example, bilateral development cooperation projects aim to improve the skills of healthcare facility staff or increase the use of data for hospital management. The effectiveness and impact of interventions to strengthen SRH facilities is examined in a number of studies (Asingwire et al., 2019; Gage et al., 2022; Gomez et al., 2018; Quaife et al., 2021; Ugaz et al., 2017; Weldearegay et al., 2022). Larson et al. (2019), for instance, show that interventions which focus on the quality of care for pregnant women improve the quality of SRH services and increase their use, which can increase the number of births in SRH facilities.

²³ This is also indirectly linked to the decline in STIs. As this is not part of the area of intervention, such contributions are considered by the evaluation to be unintended (positive) effects (BMZ, 2023b). This results chain, which links the strengthening of SRH facilities with an improvement in the quality, availability and use of SRH services, is examined in some scientific studies, particularly in relation to mentoring and training interventions as well as interventions to improve the quality of healthcare services (Asingwire et al., 2019; Gage et al., 2022; Gomez et al., 2018; Muhammed et al., 2023; Quaife et al., 2021; Ugaz et al., 2017; Ward et al., 2020).

²⁴ By reducing financial access barriers, for instance, bilateral development cooperation interventions aim to ensure that financial issues do not prevent structurally marginalised groups in particular from receiving treatment or counselling in healthcare facilities. These links can also be found in studies that analyse the effects of health finance interventions on the acceptance, availability and use of SRH services. Abuya et al. (2018) and Kuwawenaruwa et al. (2019), for example, found that the abolition of fees for SRH services and the introduction of direct payments to healthcare facilities increase the quality of care and the use of healthcare services. Furthermore, studies show that conditional cash transfers to rights-holders have a positive effect on the use of SRH services (Choudhury and Borah, 2022; von Haaren and Klöner, 2021; Lin, 2016) and on changes in sexual and reproductive behaviour, inter alia by improving the economic situation of women (Austrian et al., 2022; Dervisevic et al., 2021; Heinrich et al., 2017).

²⁵ Corresponding studies refer, for example, to effects of activities that aim to strengthen the competencies of healthcare personnel for youth-friendly counselling on family planning counselling (Asingwire et al., 2019).

²⁶ This results chain is found in a number of scientific studies that examine different types of interventions, such as interactive SRH education (Ma et al., 2022), so-called girls-group and safe-space activities (Austrian et al., 2022; Mercy Corps, 2015), general educational activities (Mbizvo et al., 2023) or teacher training programmes (Brudevold-Newman et al., 2018; Chaosurin, 2018; Yohanna et al., 2023). In addition, there are several studies that investigate community mobilisation and dialogue activities or the impacts of collaboration with specific groups, such as youth clubs (Field et al., 2018; Nafisah et al., 2019). This category also includes activities aimed at media campaigns influencing sexual and reproductive behaviour (Beaudoin et al., 2016; Chaudhary et al., 2023; Ward et al., 2020).

To achieve the desired impacts in these three areas, the BMZ envisages a series of activities that are to be adapted to the respective context and implemented in bilateral development cooperation interventions.²⁷ Based on the activities mentioned in the core area strategy and activities implemented in ongoing development cooperation interventions, a total of five areas of activity can be identified here: activities to strengthen policy and administrative management, to provide SRHR infrastructure and products, to strengthen SRH providers, to strengthen SRH finance and to further develop, expand and implement SRHR counselling and awareness-raising (for more detailed information see the online annex). Each of these areas comprises a number of different activities that can be implemented within a single intervention. For example, an intervention can advise local authorities and at the same time improve the capacity of healthcare facilities.

2.4 Implementing the SRHR area of intervention

Between 2011 and 2022, the BMZ spent a total of 1.2 billion euros on promoting SRHR. This is equivalent to around two per cent of all BMZ funds during this period.²⁸ During the period under review, the BMZ's disbursements of Official Development Assistance (ODA) for SRHR increased in absolute terms (see Figure 2): While a slight decline in ODA disbursements was observed from 2016 to 2017, the figure rose again continuously between 2017 and 2022. Relative to all BMZ funding, however, disbursements for SRHR have not increased in recent years. After their share rose to just over two per cent of total BMZ ODA between 2011 and 2016, it fell back to below two per cent in the following years. In 2022, it stood at 1.6 per cent despite the increase in total expenditure.

Box 3 Operationalising sexual and reproductive health and rights

Concerning operationalisation of the area of intervention, this evaluation follows the BMZ's definition and extends it to include specific relevant purpose codes. Since the BMZ initiative was adopted in 2011, the official development assistance provided for sexual and reproductive health and rights have been recorded by the Development Assistance Committee of the Organisation for Economic Co-operation and Development using the Creditor Reporting System (CRS)²⁹ purpose codes. This includes the following purpose codes: "Reproductive health care" (CRS code 13020), "Family planning" (CRS code 13030) and "Personnel development for population and reproductive health" (CRS code 13081).³⁰ The evaluation adopts this way of operationalising SRHR. It also includes interventions that fall under other purpose codes which also relate to the core content of the area of intervention, such as interventions designed to contribute to "Ending violence against women and girls" (CRS code 15180) and "Population policy and administrative management" (CRS code 13010).³¹

²⁷ The context-specific use of approaches is significant in that, as scientific studies generally point out, the effectiveness and impact of SRHR interventions depends largely on the prevailing conditions in the partner countries concerned (Starrs et al., 2018; UNFPA, 2021a; an overview of all contextual factors can be found in the online annex).

²⁸ The BMZ manages the majority (96 per cent) of all German ODA disbursements for SRHR.

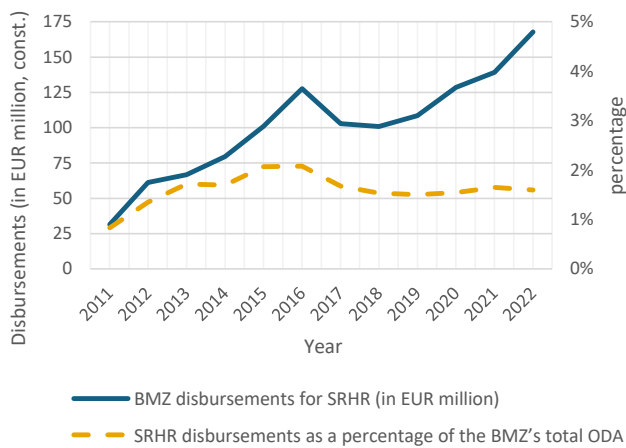
²⁹ An overview of the CRS purpose codes used in German development cooperation can be found on the BMZ website: <https://www.bmz.de/de/ministerium/zahlen-fakten/oda-zahlen/hintergrund/foerderbereichsschluesel-35676>, accessed on 18 October 2023. These purpose codes meet the OECD DAC requirements for CRS reporting. Further information can be found here: <https://webfs.oecd.org/oda/DataCollection/Resources/DAC-CRS-CODES.xlsx>, accessed on 18 October 2023.

³⁰ This also includes contributions to the International Planned Parenthood Federation (IPPF), the Maternal and Newborn Health Thematic Fund of the United Nations Population Fund (UNFPA) and UNFPA Supplies. Core contributions to the UNFPA and to the World Bank-hosted Global Financing Facility for Women, Children and Adolescents (GFF) are not eligible as contributions to the initiative (doc xxv).

³¹ Besides the above, there are also other CRS purpose codes that cover aspects of SRHR, such as those for "STD control including HIV/AIDS" (CRS code 13040) and "Women's rights organisations and movements, and government institutions" (CRS code 15170). However, since these are not essentially part of the area of intervention they are not included in this evaluation. Furthermore, there are other ways of recording funds for the promotion of SRHR. For example, the evaluation team analysed comparative calculations using an approximation of the Muskokaz method and the Donors Delivering SRHR tracking method. However, as these are each focussed on specific elements of SRHR, they were not included in this evaluation (see online annex).

By international comparison, Germany is one of the key development partners for SRHR. If the operationalisation used in the evaluation is applied, Germany was the sixth-largest bilateral donor for SRHR in the period under review (1.3 billion euros). Between 2011 and 2022, by international comparison the USA spent the most funds on promoting SRHR (12.6 billion euros), followed by the UK (4.8 billion euros), the Netherlands (2.1 billion euros), Canada (1.8 billion euros) and the European Union (EU) (1.4 billion euros). With a share of less than two per cent, spending on SRHR remains low as a proportion of total German ODA despite the high contributions. Other development partners, most of which have smaller economies, gave higher priority to SRHR. These include the Netherlands (five per cent of their ODA), Sweden (three per cent), Norway (over two per cent) and Iceland and Luxembourg (both under two per cent).

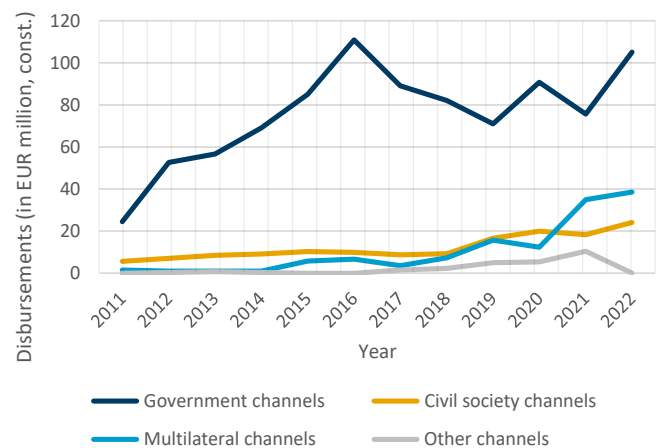
Figure 2 ODA disbursements by the BMZ for SRHR 2011–2022 (absolute and relative)



Source: DEval's own calculation and graphic based on the CRS data of OECD DAC, 2011–2022.

The largest share of the BMZ's ODA disbursements for the promotion of SRHR during the period under review was implemented through government channels. At 912.6 million euros, this accounted for 75 per cent of all ODA disbursements for SRHR (see Figure 3).³² During the period under review, 147.6 million euros (12 per cent) was disbursed through German and international civil society organisations. The majority of these ODA disbursements (110 million euros) were implemented by a single international civil society organisation, the International Planned Parenthood Federation (IPPF).³³ Also of major importance for the area of intervention are multilateral organisations, through which a total of 129.3 million euros (11 per cent) was disbursed between 2011 and 2022.

Figure 3 ODA disbursements by the BMZ for SRHR by channel 2011–2022 (absolute)



Source: DEval's own calculation and graphic based on the CRS data of OECD DAC, 2011–2022.

³² The funding to promote SRHR is implemented primarily through KfW Development Bank as part of Financial Cooperation (FC) and the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) as part of Technical Cooperation (TC). However, it is not possible to perform an analysis of CRS data disaggregated by bilateral implementing organisation, as the relevant information was not recorded uniformly in the CRS during the period under review.

³³ Overall, 74 per cent of all funding for civil society organisations was implemented through international civil society organisations during the period under review. This percentage did not change over the course of that period. The OECD DAC definition is used to distinguish – in this case – between German and international civil society organisations. Of the international civil society organisations, only certain organisations recognised by the OECD are included. An overview of these organisations can be found here: <https://webfs.oecd.org/oda/DataCollection/Resources/DAC-CRS-CODES.xlsx>, accessed on 19 December 2023.

Recently, the importance of multilateral and civil society organisations for implementing the area of intervention has increased. While the proportion of earmarked funding for multilateral organisations was rather low until 2017, since then it has risen continuously, reaching 23 per cent of all funding in 2022.³⁴ The proportion of funding implemented by civil society organisations increased until 2019, since when it has remained unchanged at around 15 per cent of SRHR funding.

While the majority of bilateral funding is spent specifically in individual countries, funding implemented by multilateral and civil society organisations is usually not country-specific. In the period under review, 88 per cent of bilateral funding (799.7 of 912.6 million euros) was allocated to specific partner countries. Similarly, 96 per cent of the funding implemented by German civil society organisations (35.9 of 37.9 million euros) can be assigned to individual countries. By contrast, only nine per cent of the ODA funds disbursed through multilateral channels (12.2 of 129.3 million euros) and five per cent of the funds disbursed through international civil society organisations (5.1 million of 110.2 million euros) can be assigned to individual countries.

In terms of content, there is a clear focus of the BMZ's ODA disbursements on the promotion of reproductive health.

Overall, 75 per cent of all BMZ SRHR funds were disbursed under the “Reproductive health care” purpose code during the period under review (916.7 million euros). The “Family planning” purpose code, under which the second-highest funding amount (154.7 million euros) was disbursed, is well behind with a share of 13 per cent. At around seven per cent of all BMZ ODA for SRHR (86.4 million euros), only the purpose code “Ending violence against women and girls” is also significant. This purpose code was only introduced in the CRS in 2017, since when it has increased significantly.³⁵ It is the only purpose code that is also implemented through multilateral channels extensively (around 38 per cent). More than 75 per cent of all other purpose codes are implemented through bilateral development cooperation.

Most of the BMZ's ODA is channelled to African countries. In the period under review, 711 million euros (59 per cent of total ODA disbursements for SRHR) were spent on African countries (see online annex).³⁶ The countries of South, East and Central Asia and Oceania received 201.2 million euros (17 per cent) in the period under review, while 58.7 million euros (five per cent) went to countries in the Middle East and 23.1 million euros (two per cent) to countries in Central and South America. The remaining 221.4 million euros (18 per cent) were distributed across Europe and entire regions, or were not specified geographically.

³⁴ It is not possible to extract information on core contributions from donors to multilateral organisations from the CRS data, as these funds are used freely by the organisations and it is therefore not possible to assign them to SRHR projects. The so-called earmarked contributions are ODA contributions from donors to multilateral organisations for specific interventions, which means they can be assigned to SRHR. Particularly important multilateral partners of the BMZ in the period under review were the Economic Community of West African States (ECOWAS; a total of 28.3 million euros), the United Nations Population Fund (UNFPA; a total of 28.2 million euros), the World Bank (a total of 21.4 million euros), the United Nations Development Programme (UNDP; a total of 20 million euros) and the Central African Economic and Monetary Community (CEMAC; a total of 17.9 million euros).

³⁵ After this purpose code was introduced, the total funding allocated rose continuously to around 20 per cent in 2022. However, this increase does not necessarily imply an increase in the importance of the respective purpose code. It is possible that previously funded interventions were subsequently labelled with the new purpose code. Furthermore, the informative value of the CRS purpose codes is very limited. As the CRS only provides for the assignment of one purpose code, only the most important area of activity can be specified. In practice, however, interventions can encompass several areas of activity, which are therefore not reflected in the CRS statistics.

³⁶ The majority of this funding (58 per cent) was disbursed to countries in sub-Saharan Africa. During the period under review, only 0.2 per cent of all funding for SRHR was disbursed to countries in northern Africa.

3.

EVALUATION QUESTIONS AND METHODS

3.1 Evaluation questions and assessment criteria

The area of interest is structured around the six OECD DAC evaluation criteria (OECD-DAC, 2019). The evaluation questions (EQs) were formulated on the basis of these criteria. All six evaluation criteria were included in the evaluation (see Annex 8.2):

- **Relevance:** Here the evaluation focused first on the relevance of bilateral interventions³⁷ for rights-holders and marginalised groups in terms of their SRHR needs (see EQ 1.1 in the evaluation matrix).³⁸ Second, it examined the relevance of interventions against the background of policies and priorities of German development cooperation and partner governments (EQ 1.2). The assessment criterion (AC) here was reference to the respective policy priorities.
- **Coherence:** First, the evaluation analysed knowledge on other bilateral interventions that can be linked to SRHR and on the coordination between such interventions in partner countries (internal coherence). Building on this, the evaluation also examined knowledge on and coordination with interventions of other development partners (external coherence; both EQ 2.1). Furthermore, it analysed empirically the respective roles of TC and FC in implementing the area of intervention (EQ 2.2).
- **Effectiveness:** Effectiveness was examined in relation to the following criteria: degree to which the direct objectives of the intervention were achieved (EQ 3.1); contribution made by interventions to strengthening SRH services and eliminating barriers to access (EQ 3.2); and contributions of the interventions to strengthening SRR, with a focus on contributions to strengthening SRHR counselling and awareness-raising as well as on changes in the knowledge and attitudes of girls and women as well as of people in their environment.³⁹ Factors affecting the achievement of direct objectives were also identified (EQ 3.4).
- **Impact:** First, the evaluation analysed contributions made by bilateral interventions to strengthening SRH and SRR, as well as to gender equality and creating the conditions required for a demographic dividend (EQ 4.1). Second, it identified factors affecting impact (EQ 4.2).
- **Efficiency:** The evaluation analysed the rating of the higher-level efficiency of bilateral interventions, as well as their production efficiency and allocation efficiency (EQ 5).⁴⁰
- **Sustainability:** With this criterion, the evaluation analysed potential for the durability of impacts – above all the interest and ability of target groups to maintain positive impacts over time (EQ 6).

Most of the evaluation questions (EQs) were assessed using the DEval rating scale. The scale includes the following categories: “fulfilled”, “mostly fulfilled”, “partially fulfilled”, “barely fulfilled” and “missed” (see Annex 8.1).⁴¹

³⁷ The term “bilateral development cooperation interventions” is used hereinafter as a synonym for “development cooperation modules”. In the German development cooperation system, “modules” are bilateral official development cooperation interventions that may comprise several components within which activities are implemented. Each module is implemented by one implementing organisation only. Modules may be implemented as part of a larger thematic development cooperation programme that defines the strategic framework for a thematic area within a partner country. While systematic monitoring and regular evaluations are planned for modules, this procedure currently does not exist for development cooperation programmes (doc xvii). Evaluations at the level of development cooperation programmes are currently being developed and piloted.

³⁸ Assessment criteria (ACs) are derived from the BMZ’s strategic requirements and operationalised using indicators. The latter are either also derived from the strategic requirements or identified by consulting other sources (see Section 2.3). The ACs and corresponding indicators are contained in the evaluation matrix in Annex 8.2. Regarding the relevance for rights-holders, a distinction is drawn between more SRH-related needs and more SRR-related needs. This distinction is important for the summary analysis. It does not imply, however, that the two areas can be clearly separated.

³⁹ This distinction between SRH-related and SRR-related objectives is based on the distinction between the two tracks as derived from the core area strategy (see Sections 2.2 and 2.3). This makes it possible to analyse the outcomes separately in each area. This separation does not imply that there are no interdependencies between the two areas, or that specific activities of interventions cannot also contribute to both tracks.

⁴⁰ Production efficiency addresses the cost-benefit ratio, based on outputs. By contrast, allocation efficiency examines the ratio between costs and benefits in relation to outcomes (see Palenberg, 2011).

⁴¹ Besides these five categories, the DEval rating scale also includes a sixth category – “exceeded”. Since the rating criteria used in this evaluation already represent a maximum with regard to the requirements for the area of intervention, it makes no sense to use a category “exceeded”. It is therefore not used in this evaluation.

3.2 Design of the evaluation

The theory-based approach

The evaluation follows the approach of a theory-based evaluation, and is therefore founded on a so-called programme theory. A programme theory sets out how one or more interventions should contribute towards objectives and impacts (Funnell and Rogers, 2011). The programme theory maps the object of the evaluation and specifies activities (Theory of Action) as well as intended direct and indirect impacts (Theory of Change; Chen, 2005; Funnell and Rogers, 2011). It also includes hypotheses concerning how impacts are to be achieved and what conditions must be in place for this. Programme theories are often visualised as flowcharts that depict the relationship between activities and impacts (Lemire et al., 2023).

The objectives and impacts listed in programme theories form the basis for assessing the object of the evaluation. The outline of the programme theory contained in Section 2.3 of this evaluation contains the BMZ's requirements for the SRHR area of intervention as well as intended impacts that development cooperation as a whole should achieve in partner countries (see Box 2 in Section 2.3). This forms the basis for formulating evaluation criteria and indicators, which are defined in the evaluation matrix for each EQ (see Annex 8.2). In this way, empirical information is aligned with the BMZ's intended objectives and impacts as defined in the programme theory.

The human rights-based evaluation approach

The evaluation follows the approach of a human rights-based evaluation (HRBE) and incorporates human rights standards and principles as comprehensively as possible. This approach requires human rights standards and principles (equal opportunities and non-discrimination, participation and empowerment, and transparency and accountability)

to be anchored in the planning of the evaluation, the definition of the area of interest, data collection and analysis, reporting and knowledge transfer (OECD, 2023; OHCHR, 2018; UNEG, 2014). This goes hand in hand with the aspiration to focus on marginalised groups in the evaluation and shift to a human rights perspective. This means that people addressed by interventions, who are often referred to as the "target group", are referred to as "rights-holders". From this perspective, state actors are considered "duty-bearers" (BMZ, 2011).

The activities implemented as part of the evaluation comply with conventional evaluation standards or good scientific practice; in some cases they also go beyond these (DeGEval, 2016; DFG, 2022). Inter alia the following activities were implemented (see online annex):

- **Inclusion of human rights in the area of interest:** Human rights and human rights standards were included both in the description of the object of the evaluation and in the formulation of the EQs and ACs.
- **Inclusion of rights-holders and their perspective in data collection.** In the case studies, data collection was designed such that the perspective of rights-holders or their representative structures could be included (see Section 3.3.1). To include marginalised groups, human rights context analyses were also conducted. In the scenario analysis, country-specific scenarios were created together with rights-holders (see Section 3.3.2).
- **Participation of rights-holders in data analysis and synthesis.** In the case study countries, interpretation workshops were conducted together with rights-holders in order to involve them in the analysis and interpretation of findings concerning them.
- **Inclusion of rights-holders in the knowledge transfer of evaluation findings.** Once the evaluation has been completed, selected findings will be prepared and made available to rights-holders in the case study countries.

The method integration-based approach

The evaluation pursues the approach of a method integration-based evaluation. Here, elements of the mixed methods approach, which involves the joint use of qualitative and quantitative methods, are combined with elements of the multi-method research approach. The latter aims to combine methods with case-centred and cross-case causal inference (Goertz, 2017; Johnson et al., 2007), and triangulates different methods or sources of information.⁴² The method integration approach raises the quality of the findings, for instance by offsetting the limitations of individual methods with further methods, depending on the area of interest.

3.3 Methods of the evaluation

3.3.1 Retrospective methods

To answer the EQs, development cooperation interventions that had already been completed or were currently ongoing during the period under review were analysed. For the case studies, ongoing interventions were selected in which activities had already been implemented. The evaluation synthesis included development cooperation interventions evaluated during the period under review, and German ODA disbursements were examined in the secondary data analysis for the period.

Case studies

The relevance of interventions for rights-holders and their coherence, effectiveness and impact were analysed on the basis of criteria in six selected case study countries.

In-person data collection was used in two countries (Malawi and Togo) and remote data collection in four countries (Guinea, Yemen, Cameroon and Kyrgyzstan). The countries were selected according to the following criteria: duration of ongoing development cooperation interventions⁴³, current importance of the partner countries for implementation of the area of intervention⁴⁴ and social, political and economic contextual factors for SRHR⁴⁵. Furthermore, where possible, countries were selected in which both TC and FC interventions were implemented. For the case studies with in-person data collection, countries were selected in which interventions also implemented SRR components and in which contextual factors made it more likely that the objectives would be achieved. For the case studies with remote data collection, countries were selected that had the most diverse contexts possible (e.g. with regard to the conflict status of the partner country) and that were located on different continents.

In the case study countries with in-person data collection, the emphasis was on collecting qualitative data through semi-structured interviews and focus group discussions. The focus here was on rights-holders: women and men of different ages and social backgrounds and from different intervention regions of German development cooperation participated in semi-structured focus group discussions.⁴⁶ In addition, project staff and responsible officers of bilateral development cooperation interventions, lead agencies, implementation partners, representatives of civil society and selected other development partners were interviewed. The discussions were held in the respective local language. The guided interviews and discussions were aligned with the EQs. They were audio-recorded, transcribed, translated and coded in accordance with the evaluation matrix. A total of 109 focus group discussions and interviews were conducted in this context.

⁴² The rating of the degree to which the evaluation criteria are fulfilled is also subject to triangulation. Detailed information on this can be found in Annex 8.1 and the summaries of findings in Chapter 4.

⁴³ Interventions in case study countries needed to have been under implementation for more than one year at the time of the evaluation.

⁴⁴ For the case study countries with in-person data collection, this was measured by implementation of the area of intervention in 2023 as part of the core area, or within the designated scope for bilateral development cooperation outside those areas. For the remote case study countries, this was measured by the amount of funding allocated to the partner country in the medium and long term.

⁴⁵ This was measured based on the socio-political environment for SRHR – such as the demand for family planning or the prevalence of modern contraceptives – as well as the socio-economic environment, determined using the individual dimensions of the Human Development Index (HDI). Current armed conflicts were also taken into account as a constraining factor.

⁴⁶ The loose structure of these interviews and discussions allows open responses, and thus the capture of attitudes and assessments that are meaningful to the interviewees (Dannecker and Vossemer, 2014). This approach is particularly important when collecting data from structurally marginalised groups, as it offers opportunities to incorporate participatory elements and respond to the specific needs of the interviewees.

In the case study countries with remote data collection, the focus was on conducting online interviews with groups of people involved in the project. For each intervention, interviews were conducted with project staff, duty-bearers (e.g. lead agencies) and people from organisations representing rights-holders (such as civil society organisations⁴⁷). These guided interviews were also recorded, transcribed and then coded in accordance with the evaluation matrix. A total of 15 interviews were conducted in this context.

Evaluation synthesis

A systematic synthesis of the findings of all project evaluation reports published during the period under review guaranteed a standardised analysis of the evaluation criteria. Evaluation reports on interventions that could be assigned to the area of intervention and that took place between 2011 and 2023 were systematically coded and analysed both qualitatively and quantitatively.⁴⁸ This involved 70 reports (29 TC interventions and 41 FC interventions).⁴⁹ These were assessed in advance for their methodological quality

using nine indicators frequently used in meta-evaluations (Guffler et al., 2022; Noltze et al., 2018; Polak et al., 2022).⁵⁰

Secondary data analysis

To analyse impact, several data sets were combined. For the macro-quantitative analysis, data sets⁵¹ from the Demographic and Health Survey (DHS), the World Bank and the United Nations Development Programme (UNDP) were combined with OECD DAC CRS allocation data (see Box 3).⁵² Further data sets were used for control variables in order to eliminate time-variant confounding factors.⁵³

As part of the analysis, the relationship between intended impacts in the area of SRHR and ODA disbursements by the BMZ for SRHR was analysed. Average changes in maternal mortality, unintended and early pregnancies, attitudes towards GBV and harmful practices, the use of modern contraceptives and gender inequality at national level in partner countries were analysed as a function of the amount of BMZ ODA disbursements (further details on the variables can be found in the online annex).

47 Due to the virtual collection of data, it was not possible to conduct focus group discussions with directly addressed rights-holders in the remote case studies. First, it was not possible to systematically identify rights-holders due to the distance; second, virtual group discussions could only be realised to a limited extent due to technical limitations. Consequently, organisations representing civil society were approached systematically to ensure that they were as representative of the rights-holders as possible and could communicate the views and experiences of those they represented.

48 This approach is based on the narrative synthesis procedure, in which the findings of scientific studies are qualitatively synthesised and elucidated (Dixon-Woods et al., 2005; Popay et al., 2006; Ryan, 2013). The evaluation synthesis builds on existing cross-sectional analyses of evaluation reports from the field of SRHR (docs xxiii and xxiv). The synthesis conducted as part of the present evaluation took these findings as a starting point and deepened them by (1) broadening the focus of the synthesis and including evaluation reports from a longer period, and (2) strengthening the methodological quality of the analysis.

49 Evaluations of interventions that began before 2011 were also included. Forty-eight evaluations analysed interventions that began before 2010, while 22 analysed interventions that began in 2010 or later. This means that some of these interventions were formulated under the requirements of earlier BMZ strategies. Nonetheless, they were included in the evaluation synthesis for two reasons: (1) The core elements of the strategic requirements display a high degree of continuity (see Section 2.2). Most of the core elements of more recent strategies were already part of earlier ones. (2) These interventions were part of the object of the evaluation during the evaluation period, as some of them were continued long after the BMZ initiative was adopted. Despite the diversity of the evaluation reports, which is increased by the fact that the interventions were implemented separately by TC and FC, an overarching analysis of the evaluation findings is methodologically feasible. The analysis is based mainly on the qualitative content analysis of the findings described in each report. Accordingly, differences between the reports can be brought to light. It is also possible to perform a quantitative analysis of the ratings made in the evaluation reports, as only the rating of the evaluation criterion at the time of the evaluation is included. In terms of content, however, the scores cannot be compared with each other.

50 The indicators rated were the presence of evidence for the findings, the discussion of causality within the design, verification of the plausibility of hypotheses, the quality of indicators, the use of a variety of methods, the triangulation of findings, the systematic selection of respondents and the presentation of results hypotheses and of the Theory of Change.

51 DHS data: <https://dhsprogram.com/data/>; World Bank data: <https://databank.worldbank.org/home.aspx>; UNDP data: <https://hdr.undp.org/data-center>; OECD DAC CRS data: <https://data-explorer.oecd.org/>; all accessed on 11 June 2024.

52 From the CRS dataset, all 28 partner countries of German development cooperation were selected that received ODA disbursements of at least 2 million US dollars in BMZ funding for SRHR in the period under review from 2011 to 2022 (see online annex), and in which at least one DHS dataset was published in the period under review. It was not possible to include the partner countries Somalia, Uzbekistan, Viet Nam, Ecuador and Lebanon in the analyses, as no DHS data is available for them for the period under review.

53 The control variables are SRHR disbursements by other donors (CRS data); GDP per capita (World Bank data); population (World Bank data); conflict status of a country (UCDP/PRIO Armed Conflict data: <https://ucdp.uu.se/downloads/>; accessed on 11 June 2024); and governance and democracy indices (Bertelsmann data: <https://bti-project.org/en/methodology>; accessed on 11 June 2024).

The data was analysed using bivariate and multivariate statistical methods. As there were no continuous data series for each partner country on each SRHR target indicator over the entire period under review, various dynamic panel models were applied in order to test the robustness of the findings.⁵⁴ The analysis thus allows the statistical relationship between financial contributions and changes in SRHR variables to be demonstrated. However, it is not possible to draw any conclusions concerning causal relationships based on the analysis. Given the focus on national averages, the findings of this analysis complement the findings of other methods. However, they cannot be directly compared with them, as they do not examine impacts from the programme perspective.

Analysis of scientific literature

To contextualise the sustainability and efficiency ratings of interventions and their focus on marginalised groups, the findings of scientific studies were systematically analysed. An evidence gap map (EGM) of SRHR interventions in low- and middle-income countries was created, thus capturing the systematic collection and visualisation of existing scientific evidence (Khan et al., 2024).⁵⁵ Based on the EGM, an evidence synthesis was then compiled which brought together the findings of all studies on sustainability and efficiency as well as on the effectiveness of the interventions for structurally marginalised groups.

3.3.2 Prospective method

The retrospective methods were supplemented by a scenario analysis. This was designed to consider possible future opportunities and challenges for strengthening SRHR in partner countries. Forecasts or trend analyses often predict a single, supposedly probable future and thus suggest certainty in this respect. Scenarios, on the other hand, are more complex, as they include not only trends (Mißler-Behr, 1993) but also a large number of uncertainties and variable influencing factors. They therefore allow an open view of plausible future developments, which makes it easier to formulate recommendations.⁵⁶

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⁵⁴ This included analyses (a) with and without one-year lagged data for the independent variable and the control variables on the SRHR target indicators; (b) with and without fixed effects (FEs) for DHS target indicators for the year and for World Bank and UNDP target indicators for the year and country; and (c) with and without control variables (see the online annex for details).

⁵⁵ The EGM follows a human rights-based and holistic understanding of SRHR. In contrast to other existing EGMs on the same topic, the focus of this map was not narrowed down in terms of the region of intervention or individual target groups. Furthermore, qualitative studies with a high-quality causal design were included alongside quantitative studies. The EGM therefore goes beyond existing SRHR EGMs (such as IOB, 2021; Rankin et al., 2016). The map is available online here: <https://www.zeimimpact.org/evidence-hub/publications/evidence-gap-maps/sexual-and-reproductive-health-and-rights-low-and>, accessed on 19 November 2024.

⁵⁶ Previous future-oriented research on SRHR has mainly used trend analyses and projections, while comprehensive scenario analyses have rarely been carried out. Moreover, the focus was often only on partial aspects of SRHR, which meant that a holistic view of the field was lacking. This scenario analysis therefore contributes to existing research by presenting a detailed analysis that both comprehensively covers SRHR and takes into account specific challenges in DAC countries. It is most comparable to a study by UNFPA (2022b); the latter developed four future scenarios on uncertainties and geopolitical tensions that could affect the equitable distribution of SRHR services. Other relevant studies include the simulation of maternal mortality up to 2050, published in "Nature Medicine" (Ward et al., 2023), the "Megatrend Gender Shift" study published by the Zukunftsinstitut (<https://www.zukunftsinstitut.de/zukunftsthemen/megatrend-gender-shift>, accessed on 12 December 2024), the analysis of global megatrends for SRHR in Kyrgyzstan (UNFPA, 2021b) and the identification of technological innovations in the field of global health by "2023 Emerging Technologies" (WHO, 2023a). Finally, the "Governing Uncertainty" report (Day and Passarelli, 2021) highlighted the impact of global governance trends on SRHR, particularly in fragile regions.

The scenario analysis followed the five steps of a standardised process according to Kosow and Gaßner (2008). This included defining the scenario field and identifying influencing and key factors based on scientific findings on SRHR. Manifestations of key factors were then developed based on indicators for possible developments. To achieve this, experts⁵⁷ were surveyed using a standardised online questionnaire (12 participants) and semi-structured interviews (ten participants). Subsequently, three employees of self-advocacy organisations were interviewed to ensure that rights-holders were represented. As experts, they contributed specific knowledge and experience from Togo and Cameroon to the scenarios without rating the interventions in the countries.

3.4 Reflections on the methodology

The possibilities and limitations of the evaluation can be illustrated at the level of the object of the evaluation, the design of the evaluation and the individual methods.

- **Operationalising the object of the evaluation:**

The evaluation is interested in examining the contributions of German development cooperation to strengthening SRHR in partner countries. To analyse this interest to an appropriate degree of quality and depth, the evaluation focuses on BMZ contributions that can be assigned to specific partner countries. These are mainly financial contributions that are implemented as part of official bilateral development cooperation. Financial contributions that cannot be assigned to a specific country were not analysed empirically. This applies, for example, to core contributions to multilateral and international organisations as well as to contributions to their overarching programmes. Furthermore, contributions implemented through German civil society channels only account for a very small proportion

of the portfolio as a whole. For this reason, they were also not included. Consequently, the evaluation provides empirical information on bilateral interventions. It is not possible to draw empirical conclusions on financial contributions implemented through other channels.

- **Design and methodology of the evaluation –**

triangulation: The evaluation is designed to answer the EQs with a high degree of reliability and validity. To achieve this, all evaluation criteria are analysed using several methods and different data sources. This triangulation of methods and data is intended to compensate for the limitations of individual methods by using other methods.⁵⁸ However, the EQs on the relevance of interventions in light of the policy priorities of the partner countries and the BMZ, as well as on efficiency and effectiveness, are answered exclusively through the evaluation synthesis. The sometimes limited quality of project evaluations can distort the findings of these EQs (Guffler et al., 2022; Noltze et al., 2018). The quality of the evaluation reports was therefore systematically examined prior to the synthesis. This was to ensure that only findings from evaluations that meet high methodological requirements were included.

- **Design and methodology of the evaluation – HRBE:**

The evaluation's human rights-based approach not only increases the methodological quality of the evaluation findings, but also ensures compliance with research ethics standards – for example by taking appropriate account of the perspective of rights-holders from partner countries (Hassnain, 2023). At the same time, implementing an HRBE can be in tension with other evaluation quality standards, such as efficiency. For this reason, each element of the HRBE was considered against the background of possible limitations for other evaluation standards. This allowed the HRBE approach to be implemented as fully as possible without jeopardising other standards.

⁵⁷ "Experts" were defined as people who use their expertise as practitioners to structure the area of intervention for others and guide their actions (Bogner et al., 2014).

⁵⁸ This can be illustrated with reference to EQ 3: the results of the case studies are of high quality in terms of the causal attribution of effects to interventions (internal validity). Given the heterogeneity of forms of intervention and the importance of different contexts for effectiveness and impact, however, the scope for generalising findings (external validity) is limited. Accordingly, the evaluation synthesis provides additional information on all interventions carried out during the period under review.

4.

**FINDINGS I:
IMPLEMENTATION
OF THE AREA OF INTERVENTION**

Figure 4 Overview of the rating of evaluation questions and assessment criteria (part 1)

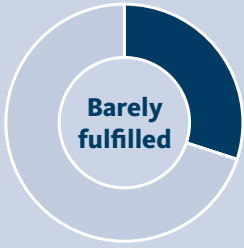








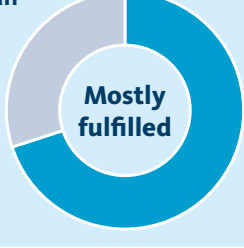

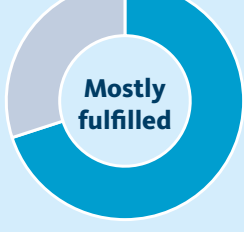

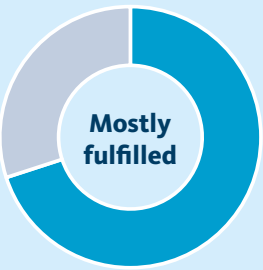
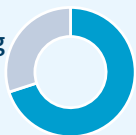

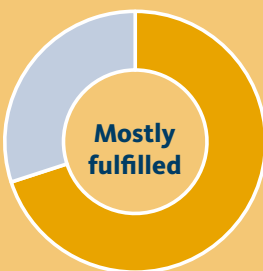
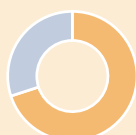

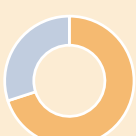



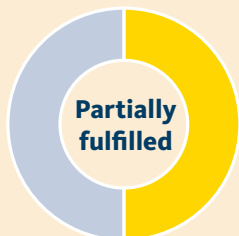


	Evaluation questions	Assessment criteria	Indicators
RELEVANCE	Alignment with needs of rights-holders 	Alignment with SRH needs  Partially fulfilled	1.1: SRH needs 1.2: Contraceptive needs
		Alignment with SRH needs  Barely fulfilled	2.1: Information needs 2.2: Equality needs 2.3: Bodily integrity needs 2.4: Self-determination needs 2.5: Legal personality needs
	Alignment with policies and priorities of partners and Germany 	Alignment with policies of Germany  Fulfilled	1.1: Consistency with policies and priorities of Germany development cooperation
		Alignment with policies of the partner country  Fulfilled	2.1: Consistency with policies and priorities of partners
COHERENCE	Coherence of interventions in partner countries 	External coherence  Mostly fulfilled	1.1: Knowledge on other actors 1.2: Coordination during planning 1.3: Coordination during implementation
		Internal coherence  Partially fulfilled	2.1: Knowledge on other actors 2.2: Coordination during planning 2.3: Coordination during implementation
EFFECTIVENESS	Achievement of objectives overall 	Effectiveness rating of interventions  Mostly fulfilled	1.1: Effectiveness rating of interventions
	Achievement of SRH objectives 	Achievement of SRH objectives  Mostly fulfilled	1.1: Quality and accessibility of SRH services 1.2: Availability of SRHR products 1.3: Reduction of financial and legal barriers to accessing SRH services 1.4: Policy environment for SRHR

Figure 5 Overview of the rating of evaluation questions and assessment criteria (part 2)

	Evaluation questions	Assessment criteria	Indicators
EFFECTIVENESS	Achievement of SRR objectives 	Achievement of SRHR counselling objectives  Mostly fulfilled	1.1: Improved quality and accessibility of counselling/ awareness-raising activities
		Achievement of SRR knowledge objectives  Mostly fulfilled	2.1: Girls and women know and accept SRR 2.2: People in their social environment know and accept SRR
		Achievement of non-discrimination objectives No rating possible	3.1: Girls and women recognise gender discrimination 3.2: People in their social environment recognise gender discrimination
IMPACT	Contribution to higher-level changes 	Impact rating of interventions  Mostly fulfilled	1.1: Impact rating of interventions
		Strengthening of self-determination  Mostly fulfilled	2.1: Strengthening of self-determination with respect to SRHR 2.2: GBV and harmful practices 2.3: Gender equality
		Strengthening of the right to SRH  Mostly fulfilled	3.1: Maternal and neonatal mortality 3.2: Unintended and early pregnancies
EFFICIENCY	Efficient implementation and achievement of objectives 	Efficiency rating of interventions  Partially fulfilled	1.1: Efficiency rating of interventions
		Individual dimensions of efficiency  Partially fulfilled	2.1: Production efficiency of interventions 2.2: Allocation efficiency of interventions
SUSTAINABILITY	Durability of impacts 	Sustainability rating of interventions  Partially fulfilled	1.1: Sustainability rating of interventions
		Individual dimensions of sustainability  Partially fulfilled	2.1: Actors' and stakeholders' interest in maintaining and ability to maintain positive impacts over time

4.1 Relevance

4.1.1 Alignment with rights-holders' needs

Summary of findings

Evaluation question: To what extent are the activities and objectives of bilateral interventions in the SRHR area of intervention aligned with the SRHR needs of directly addressed rights-holders and structurally marginalised groups? (EQ 1.1)

Methods: Evaluation synthesis and case studies.⁵⁹

Alignment with the SRH needs of rights-holders is partially fulfilled (AC 1).

- The majority of interventions are aligned with SRH needs of rights-holders, particularly as regards improving the quality of and access to specific healthcare services (indicator 1.1; mostly fulfilled).
- Needs regarding access to and the availability of modern contraceptives are only partially covered by interventions (indicator 1.2; partially fulfilled).

Alignment with the SRR needs of rights-holders is barely fulfilled (AC 2).

- The SRR needs addressed most frequently are those relating to information on sexuality and reproduction as well as gender equality. Interventions partially address these (indicators 2.1 and 2.2; partially fulfilled).
- Interventions are barely aligned specifically with needs for bodily, sexual and reproductive autonomy (indicator 2.4; barely fulfilled).
- Only very few interventions are explicitly aligned with the right to bodily integrity and to a legal personality (e.g. birth registration) (indicators 2.3 and 2.5; missed).

Relevance of interventions overall

The majority of the interventions analysed are aligned with the SRHR needs of directly addressed rights-holders.⁶⁰

According to the findings of the evaluation synthesis, this applies to 66 per cent of all interventions analysed⁶¹ (46 out of 70 reports). More interventions target SRH needs than

SRR needs. Both the evaluation synthesis and the case studies show that interventions rarely address needs for bodily integrity (indicator 2.3), bodily, sexual and reproductive autonomy (indicator 2.4) or legal personality, for example through the registration of births (indicator 2.5).

⁵⁹ The indicators and ACs are rated on the basis of both methods in accordance with the scale shown in Annex 8.1 and the categories defined therein ("fulfilled", "mostly fulfilled", "partially fulfilled", "barely fulfilled" and "missed"). The indicators analysed here are first rated on the basis of the findings of the evaluation synthesis, as these are representative of all SRHR interventions carried out during the period under review. This rating is then triangulated with the rating based on the case study findings. This means that in case of major deviations (more than one category difference between the evaluation synthesis and the case studies), the rating is corrected based on the case study findings. The rating of the indicators forms the basis for the categorisation of ACs. This is achieved by taking the average scores for all indicators assigned to the AC.

⁶⁰ Unlike the other evaluation criteria, the relevance score of the evaluation reports is not included in the assessment of the area of intervention. This evaluation distinguishes between relevance to rights-holders, and relevance against the background of partner-country and German strategies. A differentiated analysis of this kind is not possible using the score.

⁶¹ Evaluation reports can refer to more than one intervention, for example when several consecutive and related interventions have been evaluated together. However, as these evaluated interventions are always thematically related, for purposes of linguistic clarity evaluation reports and interventions are treated as one and the same thing in this evaluation.

Most of the interventions focus only on single SRH and SRR needs. Of 46 interventions, around half (22 reports; nFC=12; nTC=10) focus on one need only, around a quarter (13 reports; nFC=9; nTC=4) focus on two and the remainder on at least three (11 reports; nFC=5; nTC=6) (see online annex). There are only limited differences between TC and FC interventions. It is true that more FC interventions do not address any of the needs analysed (15 out of 41 in FC compared to nine out of 29 in TC). However, these interventions are on average older, which means that particular aspects of the current understanding of SRHR may not have been part of their focus. Furthermore, there are more FC than TC interventions in which two of the analysed needs are addressed (nFC=9; nTC=4). These interventions address either the demand for SRH services and products (indicator 1.1) plus the demand for modern contraceptives (indicator 1.2), or SRH services and products plus information on sexuality and reproduction (indicator 2.1). The proportion of TC and FC interventions within these two combinations differs in some cases. This is often linked to the approaches of the interventions: FC interventions more often address the demand for modern contraceptives or for information, and apply activities such as procurement and distribution of contraceptives plus social marketing. TC interventions more often address gender equality and focus on activities such as capacity development.

Alignment with rights-holders' SRH needs

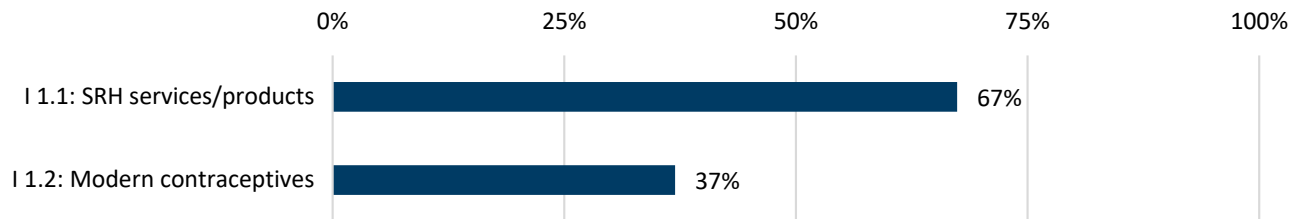
SRHR interventions primarily address the SRH needs of rights-holders. According to the evaluation synthesis, 83 per cent of the interventions (38 of the 46 reports) that address

rights-holders' SRHR needs target the need for SRH services and products such as modern contraceptives. Twelve of these interventions focus on both these needs. The main objectives of German development cooperation in the area of SRH needs involve improving supply, quality and accessibility in order to reduce maternal and neonatal mortality, and the number of unintended and early pregnancies.

The majority of SRHR interventions are aligned with rights-holders' needs for SRH services and products. Sixty-seven per cent of the interventions examined in the evaluation synthesis address these needs (31 out of 46 reports; indicator 1.1; see Figure 6). These are services and products relating to maternal and neonatal health, improved financial, geographical or cultural access to healthcare services, the quality of services and infrastructure or the expansion of social protection. According to the interviewees, interventions focussing on SRH services and products can also be found in all six case study countries: three interventions integrate elements of both needs and three are geared either more towards SRH products or more towards SRH services. Specifically, different aspects are addressed in the interventions. For example, the quality of services was improved everywhere by strengthening capacity and the quality of staff training standardisation (six case study countries). Health infrastructure was also built or rehabilitated in all countries (six case study countries). In five countries, community health workers⁶² were trained among other things to reach people in remote areas in particular. In three countries, voucher programmes are being implemented to reduce financial barriers to access.

⁶² Community health workers are deployed differently depending on the context and task. Their primary aim is to provide a culturally appropriate healthcare service to the community (Olaniran et al., 2017; WHO, 2020). Generally speaking, community health workers are members of a community who have an in-depth understanding of its culture and language. They receive specific training for their task over a period of a few weeks to several months. They perform their work as unpaid volunteers with the help of grants, or are on a fixed salary.

Figure 6 Alignment of interventions with SRH needs of rights-holders (AC 1)



Source: DEval's own calculations based on the evaluation synthesis. The bars show the respective percentage of interventions identified as addressing the different SRH needs; $n=46$.

Not all rights-holders are addressed equally here. According to the interviews, unmarried youth and young adults (four case study countries), LGBTI people (four case study countries) and people living in remote rural regions (five case study countries) and in major poverty (two case study countries) in particular do not have the same access to SRH services and products as other groups. This results from persistent stigmatisation and discrimination due to cultural norms and values directed towards diverse sexual orientation or towards sexually active young people in general (four case study countries). In the interviews, the lack of services specifically targeting young people (youth-friendly services; four case study countries), a lack of transport options to healthcare facilities (five case study countries), inadequate quality of healthcare and healthcare infrastructure (four case study countries) and high financial barriers due to the lack of general healthcare coverage in the partner countries (two case study countries) were cited as challenges.

One in three interventions implements activities that address the need for modern contraceptives. The evaluation synthesis identified 17 out of 46 interventions (37 per cent) whose activities aim to improve access to modern contraceptives and make them more widely available (indicator 1.2; see Figure 6).⁶³

In most cases, condoms and long-term contraceptives are addressed. The interventions refer to the low utilisation and lack of supply of such contraceptives to the population, particularly in rural regions (three interventions). Two interventions aim to improve access to safe pregnancy terminations. According to the interviewees in the six case study countries, the way in which modern contraceptives are provided varies depending on the rights-holders: while interventions in three countries implement activities to procure and distribute contraceptives, in the other three countries this is only possible to a very limited extent due to the political situation (one case study country), or is partly taken on by other donors such as UNFPA and local non-governmental organisations (NGOs) (three case study countries). Even in the three countries where modern contraceptives are made available, some needs remain unmet according to the interviewees. This applies in particular to limited or non-existent access for unmarried youth and young adults (three case study countries) and the lack of or only partial freedom to choose the preferred means of contraception (three case study countries). In three of the six countries, supply shortages and other logistical aspects make it particularly difficult to meet the need for modern contraceptives.

⁶³ A few interventions were excluded here which, although designed to improve access to condoms, related this to the reduction and prevention of HIV/AIDS prevalence rather than to the reduction of unintended pregnancies or the improvement of bodily and sexual autonomy.

Alignment with rights-holders' SRR needs

Around half of the analysed interventions address SRR needs.

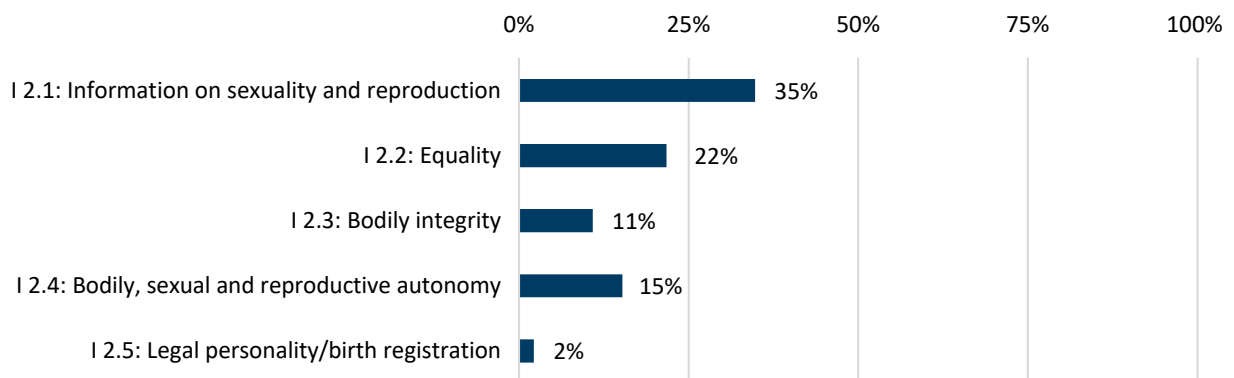
According to the evaluation synthesis, this applies to roughly 54 per cent of the interventions analysed (25 out of 46 reports). The interventions include improved quality and accessibility of counselling and awareness-raising in the area of SRHR, as well as changed attitudes, increased knowledge and greater acceptance of SRR, with the aim of increasing the autonomy of girls and women and reducing GBV and harmful practices. Almost half of these interventions (11 reports) focus on several SRR needs at the same time. This means that SRR needs are significantly less of a focus of SRHR interventions than SRH needs. The interventions in the case study countries are also less focussed on SRR needs. Although interventions in all six countries address at least one SRR need, only three of them integrate several needs at the same time.

Needs for information on sexuality and reproduction are addressed most frequently compared to other SRR needs.

The evaluation synthesis identifies 16 out of 46 interventions (35 per cent) in which knowledge on sexuality and reproduction as well as information on prevention and education were addressed (indicator 2.1; see Figure 7). These are often awareness-raising activities involving local political and

religious authorities as well as social marketing campaigns. By comparison, the findings of the case studies are clearer: interventions in all case study countries focus on information requirements. Women and young people (six case study countries), men (four case study countries) and community and religious authorities (five case study countries) are reached through information and awareness-raising activities. The activities take place in schools (three case study countries) and communities (six case study countries). They are carried out by trained healthcare personnel, community health workers or so-called peers (six case study countries), or reach rights-holders via information hotlines (two case study countries) or digital media (two case study countries) and chat groups (two case study countries). Nonetheless, according to the interviewees there are still knowledge gaps regarding sexuality and reproduction, particularly among youth (four case study countries), within the rural and remote population (three case study countries) and in very religious population groups (four case study countries). A lack of financial and human resources (five case study countries), the local security situation (two case study countries), the lack of availability of information in local languages (two case study countries) and religious and social norms and values (five case study countries) were cited as reasons for this.

Figure 7 Alignment of interventions with SRR needs of rights-holders (AC 2)



Quelle: DEval, eigene Berechnungen auf Basis der Evaluierungssynthese. Die Abbildungen geben den jeweiligen Anteil der Vorhaben an, in denen eine Ausrichtung anhand der verschiedenen SRR-Bedarfe benannt wurde; n = 46.

One fifth of the SRHR interventions analysed include activities that explicitly address the social position of women and thus contribute to gender equality. According to the evaluation synthesis, ten out of 46 interventions (22 per cent) explicitly address gender equality needs (indicator 2.2; see Figure 7).⁶⁴ In the case studies, this applies to half of the interventions. The interviewees point to links between the interventions analysed and gender equality and non-discrimination. Examples include specific services for different population groups, such as training for young mothers who then carry out awareness-raising and communication work with girls in order to prevent early and unintended pregnancies; services provided by men to men in which the providers educate about the importance of gender equality; and awareness-raising events on non-discrimination against marginalised groups within healthcare services and other institutions (three case study countries). Mobile services and the deployment of community health workers for people living in rural and particularly remote regions are also emphasised in the interviews as good ways of strengthening gender equality (five case study countries). However, major gaps were identified in regions characterised by strong religious beliefs, where structural inequality prevails. According to the interviews, in these cases there is often a lack of understanding of the importance of prenatal healthcare services for pregnant women (two case study countries), and the importance of equal access to contraceptives in order to prevent unintended pregnancies (two case study countries).

One in ten interventions addresses needs for bodily integrity. In the evaluation synthesis, five out of 46 interventions (11 per cent) were identified as addressing the need to reduce violence against women, GBV and harmful practices (indicator 2.3; see Figure 7). Examples of activities are the inclusion of FGM content in curricula to raise public awareness, and the funding of safe pregnancy terminations. The findings of the case studies show that, with a few exceptions, bodily integrity needs tend to be addressed indirectly by the activities of the analysed interventions. The few activities that do directly target GBV offer psychosocial support for victims of violence and rape (one case study country) and raise awareness of GBV, FGM and other harmful practices (five case study countries). However, interviewees state that they cannot address GBV and harmful practices in awareness-raising and public information campaigns on sexuality and reproduction in particularly religious contexts, as such activities would otherwise be rejected by community and religious authorities (two case study countries). In some cases, community health workers address these issues in private conversations with women in remote rural areas and make them aware of their rights (two case study countries). In one country, interviewees point out that changes initiated by development cooperation activities, such as the requirement to attend hospitals for births, restrict the free choice of girls and women and can lead to a violation of their right to bodily integrity (one case study country; see also Box 4).

⁶⁴ A further 12 interventions that aim to improve gender equality for women are primarily designed to reduce the HIV infection rate and the associated burden of care for female relatives. Due to this focus on HIV/AIDS, these interventions are not part of this evaluation.

Box 4 **Voices of rights-holders – respectful and culturally appropriate obstetric care**

The right to sexual and reproductive health and rights includes inter alia non-discriminatory access to sexual and reproductive healthcare services, and respectful and culturally appropriate treatment of the people who use such services.

These services also include safe births. According to the interviewees, home births continue to take place in Malawi and Togo. Obstetric care is usually performed by traditional midwives or family members with no medical training. Home births are therefore associated with a high maternal mortality rate. In both countries, efforts are being made to increase the number of births attended by qualified healthcare personnel. However, the path being taken is not always compliant with human rights:

- *“In our village, there are rules that prevent women from giving birth at home. A fee is charged for violating these rules.”* (ID 53)

Women interviewees reported that they often prefer to give birth at home because the staff in healthcare facilities treat them patronisingly, do not respect their need for intimacy or force them into a birthing position that is alien to them:

- *“When you go to the hospital to give birth, they tell you to wait. And then you give birth alone, without the help of the healthcare staff.”* (ID 51)
- *“In the hospital, we sometimes give birth outside while the students watch.”* (ID 51)
- *“My daughter was in labour and so was another woman. She was accused of not shaving her private parts. She was in pain and ended up giving birth where she was sitting, on the floor. They didn't take care of her because of how she looked. People who look dirty and have no money are neglected.”* (ID 45)

In Togo, the intervention is training healthcare staff in respectful and culturally appropriate obstetric care. It is also informing the public, traditional birth attendants and women in the local communities on how professionally assisted births take place in healthcare facilities:

- *“You can now give birth in the position in which you feel comfortable.”* (ID 91)
- *“In the past, not all women came to the hospital to give birth, but now, having become more aware, they've understood and they do come.”* (ID 99)

Very few of the interventions analysed are aligned with needs for bodily, sexual and reproductive autonomy. These few interventions focus on the autonomous use of contraceptives and the reduction of FGM. However, discriminatory laws and social, cultural and religious norms often stand in the way of implementation. The evaluation synthesis identified seven interventions (15 per cent) aligned with these needs (indicator 2.4; see Figure 7). They aim to reduce FGM, either by providing modern contraceptives for autonomous use or through awareness-raising and education work.⁶⁵ The findings of the case studies are heterogeneous in this respect: in two countries, activities explicitly designed to increase bodily, sexual and reproductive autonomy are being implemented. In another country, this is more of an indirect part of the intervention,

while in two other countries there is no such focus. Good examples include activities to educate girls and women about their right to sexual and reproductive autonomy, and sensitise men to the acceptance of these rights (four case study countries). Barriers to autonomy were also mentioned in the interviews. Here, interviewees often pointed to discriminatory laws and social, cultural and religious norms that stand in the way of greater autonomy for girls and women and make it difficult or impossible to align interventions accordingly (six case study countries). In some of these cases, community and religious authorities are being sensitised and women are being approached directly through community health workers or peers (five case study countries), although it was difficult or impossible to implement these activities in very religious regions (two case study countries).

⁶⁵ Modern contraceptives can indirectly contribute to reducing FGM by giving women control over their fertility and sexuality without having to resort to harmful traditional practices, which are often carried out with the intention of controlling female sexuality and preventing supposedly “illicit” sexual acts (see https://iris.who.int/bitstream/handle/10665/112328/WHO_RHR_14.12_eng.pdf?sequence=12&isAllowed=y, accessed on 21 February 2025).

The evaluation shows that almost none of the interventions have a focus on needs for legal personality or birth registration.

Only one intervention with such a focus was identified by the evaluation synthesis (indicator 2.5; see Figure 7). Two different aspects are emphasised here: first, the need to integrate women's rights into civil status registration, and second, the need to improve access to civil status certificates (particularly in rural areas). No interventions were identified in the case studies that were geared towards meeting these needs. According to the interviews, these needs do not exist among directly addressed rights-holders, but do exist among other population groups, such as internally displaced persons and refugees, who are provided for by activities of other donors such as the United Nations High Commissioner for Refugees (UNHCR) (two case study countries).

Inclusion of the needs of marginalised groups

Formally, SRHR interventions very often focus on marginalised groups such as women, children, young people and vulnerable persons. According to findings of the evaluation synthesis, women (55 out of 70 reports, 79 per cent) are specified as a direct target group in the vast majority of the interventions examined.⁶⁶ They are structurally marginalised in most SRHR partner countries of development cooperation due to patriarchal structures. In the SRHR area of intervention, they make up the main group of rights-holders addressed, as women and girls are almost exclusively the target group of corresponding activities as pregnant and birthing persons. However, interventions should address multiple discrimination through an intersectional approach. This entails an understanding of the fact that not all women in a partner country are exposed to the same forms of discrimination and the same barriers to accessing SRH services and products. Accordingly, SRHR interventions need not provide the same support to all women. Besides women, project evaluations also often name young people (28 reports, 40 per cent) and generically vulnerable groups (36 reports, 51 per cent)

as rights-holders addressed by the interventions. However, only sporadically do they provide detailed information on which specific vulnerable groups this involves.⁶⁷ The evaluation synthesis thus provides only limited information on the inclusion of groups that experience multiple discrimination.

In the implementation of the interventions, barriers to the promotion of particularly marginalised groups are evident.

As in the project evaluations, many case studies also report a strong focus on marginalised groups. However, interviews with rights-holders and their representative structures in particular show that access to SRHR services often remains difficult for particularly marginalised groups. This applies to certain groups of women, for example.⁶⁸ According to the interviews, women with disabilities, boys and LGBTI people are sometimes unable to access information on SRHR services, or can only do so to a limited extent, or experience discrimination when accessing treatment (four case study countries; see also Box 5). Young people report that interventions often lack a specific focus on their needs for youth-friendly services despite the formal focus of the interventions (two case study countries; see also Figure 7) or that services are not appropriate despite such a specific focus.⁶⁹ Furthermore, insufficient financial resources mean that women may be prioritised for SRH services at the expense of other population groups (one case study country). Furthermore, there are very few countries in which people who experience multiple discrimination are specifically supported. With the exception of mobile services and community health workers who try to reach people in especially remote areas, there are barely any approaches that specifically integrate or target particularly marginalised groups. In one country, for example, awareness-raising activities are implemented with healthcare workers and other state employees in cooperation with self-advocacy organisations to promote SRHR for LGBTI people. In most other countries, the SRHR needs of this group are addressed either not at all (three case study countries) or only indirectly (one case study country).

⁶⁶ Furthermore, many interventions also include men (46 interventions, 66 per cent), healthcare staff (six interventions, nine per cent) and institutions (four interventions, six per cent) as a main target group.

⁶⁷ In some specific cases, victims of GBV (two interventions), people with disabilities, sexual minorities, mobile population groups, ethnic minorities and migrants (one intervention each) are mentioned. Furthermore – particularly in the context of HIV/AIDS interventions – HIV/AIDS high-risk groups are mentioned in a large number of interventions (16 interventions). These include sex workers (six interventions) and people with HIV/AIDS (four interventions).

⁶⁸ In particular, these are young unmarried women, poor girls and women with disabilities, poor girls and women who live in very remote areas, and girls and women who live in very religious regions.

⁶⁹ In one case study country, for example, an app with information on SRHR was developed for young people. However, this app was not used by the young people as the content was not tailored to the target group and was not available in local languages.

Box 5 **Voices of rights-holders – people with disabilities**

While marginalised groups are the focus of sexual and reproductive health and rights interventions, the concerns of groups that experience multiple discrimination, such as people with disabilities, are barely addressed. In Malawi and Togo, people with disabilities, especially children and women from poor households, are particularly marginalised, according to the interviewees. Children with disabilities are often perceived as a burden, a source of misfortune or a disgrace to the family:

- *“Here, disability is seen as if it were a curse. If a child is born with a disability, it is said to be possessed by evil spirits.”* (ID 96)
- *“Families often refuse to register their disabled child in order to obtain a birth certificate.”* (ID 96)

Women with disabilities reported that they often experience social marginalisation:

- *“We are often forgotten, or we are excluded by our spouses and our parents-in-law.”* (ID 96)

According to the rights-holders interviewed, healthcare staff are not always sufficiently trained to adequately inform or treat people with disabilities, or healthcare facilities are not barrier-free:

- *“Sometimes people who work in hospitals are unable to communicate with people with disabilities. They find it difficult to communicate with this person who has a disability, especially if there are no relatives around who understand their language or gestures. So they ignore them.”* (ID 41)
- *“There are ramps that were built for us in the healthcare facilities. There are wheelchairs. It's a bit better now because the healthcare staff have been made more aware. But sometimes people don't notice us.”* (ID 96)

The interviews indicate that the intervention in Togo supports self-advocacy organisations of people with disabilities in raising awareness of sexual and reproductive health and rights:

- *“In the villages, we worked with healthcare centre managers to educate people with disabilities about family planning methods, pregnancy examinations and obstetric care. Through these campaigns, we make people with disabilities more aware of the fact that they have the right to be hospitalised and treated.”* (ID 96)
- *“We organised awareness-raising campaigns to show that children with disabilities can go to school. It's easier in the city, but in remote places it took a lot of work to help everyone understand.”* (ID 96)

4.1.2 Alignment with policies and priorities of partners and German development cooperation

Summary of findings

Evaluation question: To what extent are the activities and objectives of bilateral interventions in the SRHR area of intervention aligned with the policies and priorities of development partners and the BMZ? (EQ 1.2)

Method: Evaluation synthesis.⁷⁹

The alignment of interventions with policies and priorities of German development cooperation is fulfilled (AC 1).

- The evaluation reports show a strong alignment of the interventions with international standards, such as the MDGs or the SDGs, as well as with sector strategies of German development cooperation (indicator 1.1; fulfilled).

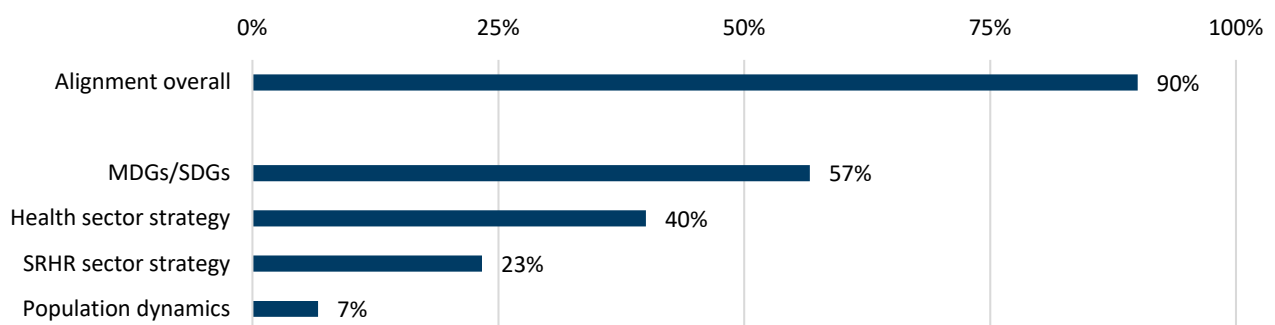
The alignment of interventions with policies and priorities of partners is fulfilled (AC 2).

- The interventions show a strong alignment with national strategies in the partner countries, such as health strategies or strategies to promote reproductive health and family planning (indicator 2.1; fulfilled).

The evaluation synthesis shows that most of the analysed interventions are aligned with the policies and priorities of German development cooperation. This applies to 90 per cent (54 out of 60 reports) of the interventions (indicator 1.1; see Figure 8). German development cooperation is aligned inter alia with international agreements. The findings of the evaluation show that – depending on the age of the interventions – the Millennium Development Goals (MDGs)

and the SDGs of the 2030 Agenda are mentioned particularly frequently (57 per cent, n=34). There are also references to the BMZ's sector strategies on health (24 reports, 40 per cent) and SRHR (14 reports, 23 per cent) or both (eight reports, 13 per cent). These are frequently cited as frames of reference for German development cooperation interventions. Strategies for population dynamics are barely mentioned (four reports, seven per cent).

Figure 8 Alignment of intervention objectives with policies and priorities of German development cooperation (AC 1)



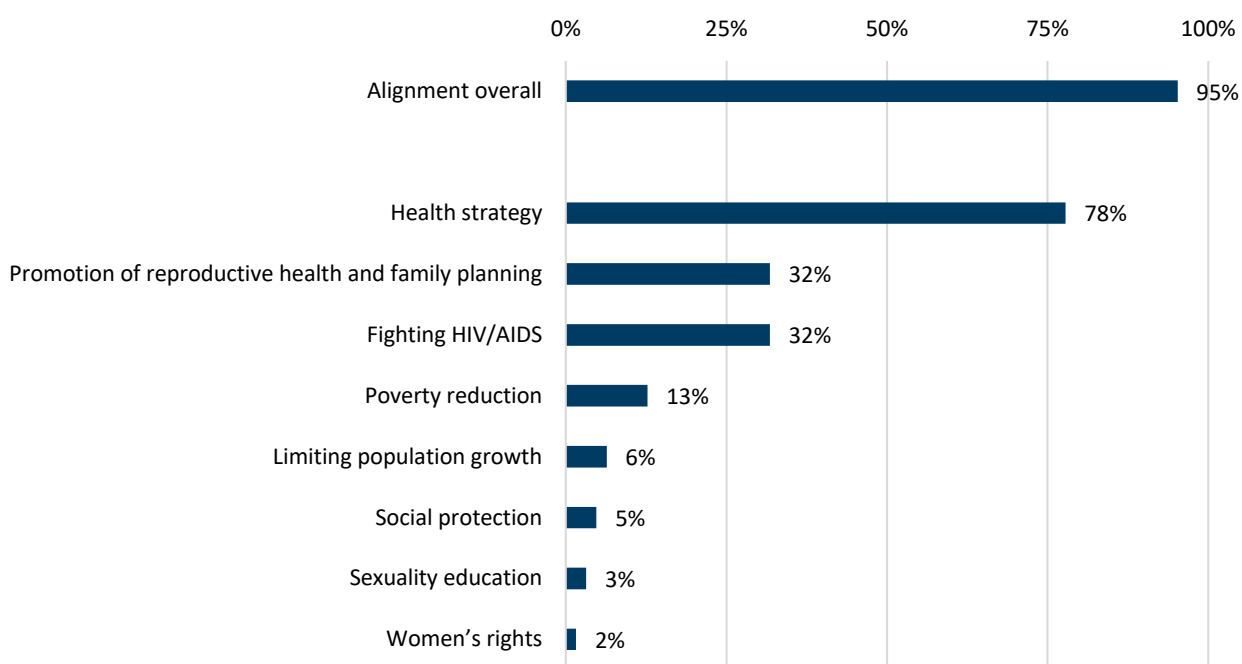
Source: DEval's own calculations based on the evaluation synthesis. The bars show the respective percentage of evaluation reports that referred to the alignment of objectives with policies and priorities of German development cooperation. Multiple references were possible; n=60.

⁷⁹ The indicators and ACs are rated on the basis of this one method using the scale shown in Annex 8.1.

The interventions analysed are aligned with the policies and priorities of the partner countries. Ninety-five per cent (60 out of 63 reports) of the interventions are aligned with strategies and priorities of the partner countries (see online annex). In more than three quarters of the interventions (49 reports, 78 per cent), national health strategies of the partner country are specified as a frame of reference for German SRHR interventions. Strategies to promote reproductive health and

family planning and to combat HIV/AIDS are specified in just under a third (20 reports, 32 per cent) of the interventions. Other strategies of the partner countries that appear in very few interventions (two to 13 per cent) include strategies for poverty reduction (eight reports), limiting population growth (four reports), expanding social protection (three reports), sexuality education (two reports) and women's rights (one report).

Figure 9 Alignment of intervention objectives with policies and priorities of partner countries (AC 2)



Source: DEval's own calculations based on the evaluation synthesis. The bars show the respective percentage of evaluation reports in which reference was made to the alignment of objectives with partner-country policies and priorities. Multiple references were possible; n=63.

4.2 Coherence

4.2.1 External and internal coherence

Summary of findings

Evaluation question: To what extent do bilateral interventions in the SRHR area of intervention cohere with each other and with the activities of other bilateral and multilateral donors? (EQ 2.1)

Method: Case studies.⁷¹

External coherence is mostly fulfilled (AC 1).

- German development cooperation staff possess knowledge of other development partners (indicator 1.1; fulfilled).
- The German development cooperation interventions analysed mostly use existing coordination mechanisms during the planning phase (indicator 1.2; mostly fulfilled) and partially use them in the implementation phase (indicator 1.3; partially fulfilled). Geographical duplication of and content-related overlaps between development cooperation interventions are mostly avoided through existing coordination mechanisms. Collaboration with regard to content only takes place sporadically.

Internal coherence is partially fulfilled (AC 2).

- Knowledge of interventions (co-)financed by the BMZ and carried out by other implementing organisations is partially in place, and is mostly limited to bilateral interventions (indicator 2.1; partially fulfilled).
- During the planning and implementation phases, some of the interventions analysed use formal coordination mechanisms (indicators 2.2 and 2.3; partially fulfilled). Formal mechanisms predominate during planning and informal mechanisms predominate during implementation. As a consequence, interventions only cohere sporadically in order to jointly achieve impacts.

External coherence

In all the case study countries analysed, German development cooperation staff are knowledgeable about the most important interventions of other development partners (indicator 1.1). Besides multilateral organisations – especially the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the UN Children's Fund (UNICEF) and The Global Fund, – and international finance organisations (primarily the World Bank), interviewees frequently mentioned the EU and the United Kingdom with its Foreign, Commonwealth and Development Office (FCDO) as important actors in the respective case study country. Knowledge of the interventions of international NGOs is also often in place.

In most of the case study countries, coordination mechanisms with these development partners are used in the planning phase; in interviews they are described as partially functional (indicator 1.2). Established coordination mechanisms at national level, which are also frequently used during the planning of German interventions, exist in all the case study countries analysed.⁷² In this context, interviewees primarily mentioned thematic working groups as a coordination mechanism (five case study countries). In a country where bilateral development cooperation is explicitly pursuing a non-governmental approach, the state no longer serves as a coordinating entity. In these interviews,

⁷¹ The indicators and ACs are rated on the basis of this one method using the scale shown in the Annex 8.1.

⁷² Bilateral coordination with partner governments is part of the formal coordination processes of bilateral development cooperation, and is manifested in government negotiations or planning missions for bilateral TC and FC interventions (doc xvi). The description of the donor landscape is part of the German development cooperation programme and its module proposals, and must therefore be considered when planning interventions. Furthermore, information on changes is provided as part of reporting (doc xvii).

interviewees instead pointed to alternative mechanisms through which other development actors organise coordination meetings (two case study countries). In two countries, these coordination mechanisms were described as having only limited functionality. According to the interviews, they do not always guarantee the geographical and thematic complementarity of the interventions. In some interviews, interviewees reported avoidable duplication in terms of content and geography (three case study countries). Overall, collaboration and utilisation of synergies between interventions is only rarely mentioned. This is only the case when development partners implement joint interventions, for example in consortia or through joint basket funding (two case study countries).

Coordination mechanisms during the implementation phase are partially utilised in case study countries (indicator 1.3).

Interviewees refer to the same national coordination mechanisms that are also relevant during intervention planning: formalised bilateral exchange with partner governments and exchange within the framework of thematic working groups (five case study countries). In some countries, interviewees state that these coordination mechanisms are only used irregularly (two case study countries) or that their use does not lead to the coordination of activities (two case study countries). For example, interviewees point out that some development partners implement their activities largely independently of the activities of other actors (one case study country) or that the same outputs are generated by several development partners (two case study countries). While interviewees emphasise coordination mechanisms at national level chiefly in the planning phase of interventions, they also emphasise that corresponding mechanisms at regional and local level are also of great importance during implementation. Such coordination mechanisms were mentioned in three countries. According to the interviewees, however, regional and local coordination differs greatly from region to region, as the interests and capacities of local actors vary.

Internal coherence

In the case study countries, German development cooperation staff are partially knowledgeable about all other interventions (co-)financed by the BMZ (indicator 2.1).

The interviewees primarily mention the most important other bilateral programmes in the area of intervention (five case study countries). In some of these countries, however, interviewees also report that their knowledge of other bilateral interventions is rather superficial and that they lack detailed information on specific activities (two case study countries). Occasionally, interviewees mention civil society interventions (co-)financed by the BMZ (two case study countries). However, interviewees do not possess full knowledge of interventions implemented by civil society in any of the countries.

Mechanisms for coordinating bilateral interventions exist in the planning phase and are sometimes used for coordination between interventions (indicator 2.2).

In all the case study countries analysed, interviewees report that formal exchange mechanisms are used to plan interventions within bilateral development cooperation as per the BMZ's requirements.⁷³ In four countries, interviewees state that these mechanisms are not always successful, particularly due to the differences between TC and FC. Examples mentioned include the different durations of TC and FC interventions (four case study countries) and different objectives and strategies (one case study country). Furthermore, unforeseen delays in interventions make continuous cooperation more difficult, as consecutive and related activities are no longer possible (one case study country). These challenges were also mentioned in interviews in one of the two countries where development cooperation programmes form the strategic framework for the individual interventions. This relates to the fact that some programme documents were outdated at the time of the analysis and that current interventions therefore no longer match the programme framework.

⁷³ For example, BMZ stipulates that questions regarding the relationship between different modules must be clarified as part of the development cooperation programme proposal (i.e. how the individual modules relate to each other, complement each other or are distinct from each other; doc xviii). Furthermore, the positioning of individual modules within the strategic framework of development cooperation must also be explicitly addressed (doc xix).

During implementation, predominantly informal exchange mechanisms between bilateral development cooperation interventions are used (indicator 2.3). In two cases, interviewees stated that the activities of individual TC and FC interventions were being implemented in a coordinated manner. In all other countries, however, interviewees only occasionally mentioned mechanisms for coordination between TC and FC,

as these are usually informal. Interviewees also mentioned regular meetings to support information sharing and coordination on specific occasions (two case study countries). In three countries, interviewees mentioned coordination through ad hoc exchanges, and in one country the coordinating role of development cooperation officers.⁷⁴

4.2.2 The roles of TC and FC

Summary of findings

Evaluation question: What roles do TC and FC interventions play in the SRHR area of intervention, and what comparative advantages and disadvantages can be identified for each? (EQ 2.2)

Method: Evaluation synthesis.

The roles of TC and FC

- At the level of impact, TC and FC both often focus on strengthening SRH. Impacts on SRR are rarely achieved in TC and FC interventions.
- TC and FC usually pursue different direct objectives: compared to TC interventions, FC interventions more often aim to improve the availability of SRH products. By contrast, the TC portfolio focuses on improving SRH services and removing barriers to accessing them.
- There are overlaps with regard to improving access to awareness-raising and education activities, which TC and FC use in similar ways.
- In terms of approaches, the roles are often separate: FC interventions more frequently use the approaches of strengthening supply chains, raising awareness and implementing training or education activities. TC interventions tend to focus more on capacity development, activities to improve infrastructure and equipment, or strengthening networks.

TC and FC interventions mainly contribute to strengthening SRH at the level of impact. All FC interventions analysed in the evaluation synthesis and 97 per cent of TC interventions aim to achieve impacts in the area of strengthening SRH (see online annex).⁷⁵ Impacts in the area of SRR are targeted by 30 per cent of all FC interventions and 28 per cent of all TC interventions.⁷⁶

Very few interventions pursue other objectives at a higher level – such as improving the conditions for the demographic dividend (three per cent of TC interventions and 22 per cent of FC interventions) or strengthening gender equality (14 per cent of TC interventions and zero per cent of FC interventions).⁷⁷ The majority of interventions focus on a single area of impact.

⁷⁴ Development cooperation officers are employees of the BMZ who are seconded to German embassies and consulates general in partner countries (see <https://www.bmz.de/de/ministerium/aufbau-und-struktur>, accessed on 4 April 2025). The BMZ stipulates that donor coordination is part of the remit of development cooperation officers (doc xx).

⁷⁵ These interventions pursue at least one of the following impacts: improving access to SRHR products, lowering maternal mortality, reducing neonatal mortality, improving the reproductive and sexual health of the population in general, improving equitable access to SRH services, reducing the spread of STIs including HIV/AIDS and improving access to health insurance.

⁷⁶ These interventions pursue at least one of the following impacts: reducing unintended pregnancies, increasing the use of contraceptives, decreasing the stigmatisation of people with STIs including HIV/AIDS and strengthening individual freedom of choice.

⁷⁷ Interventions that aim to improve the conditions for a demographic dividend pursue at least one of the following impacts: curbing population growth, reducing the birth rate and reducing the fertility rate. Interventions that aim to strengthen gender equality pursue at least one of the following impacts: reducing gender-based marginalisation and strengthening gender equality.

For example, 59 per cent of all interventions exclusively pursue impacts related to SRH. Higher-level objectives that relate more to SRR, on the other hand, are only pursued in interventions that also pursue impacts from other tracks (29 per cent of all interventions in total).

TC and FC have different direct objectives. Compared to TC interventions, FC interventions are much more likely to have the direct objective of contributing to the improved availability of SRH products (see online annex): fifty-six per cent of FC interventions pursue this objective, compared to only ten per cent of TC interventions. Similarly, there is also a clear focus in FC on strengthening SRR (49 per cent compared to 24 per cent in TC). TC interventions, on the other hand, generally aim to improve the quality of SRH services (52 per cent compared to 20 per cent of FC interventions). The situation is similar as regards the aim of reducing barriers to SRH access. This objective is pursued by 31 per cent of TC interventions and ten per cent of FC interventions. Both TC and FC interventions pursue barely any objectives at the direct impact level that relate to both SRR and SRH (19 per cent of TC interventions and 34 per cent of FC interventions). The most common interventions in both cases are those that relate exclusively to SRH (52 per cent of TC interventions and 46 per cent of FC interventions).

Capacity development, awareness-raising and information and education, as well as strengthening supply chains, are among the most common approaches in bilateral development cooperation interventions. Most of the interventions analysed use several approaches: while only one approach is used in around 13 per cent of all interventions, slightly more than half

of all interventions (53 per cent) use two approaches and a good third (34 per cent) use more than two. A total of 60 per cent of all interventions examined use the capacity development approach, and a good half of all interventions use awareness-raising and information and education activities (see Figure 10).⁷⁸ The strengthening of supply chains is often pursued in interventions (44 per cent of interventions).⁷⁹ Activities to improve infrastructure and equipment, on the other hand, are only used in just over a third of interventions, and advisory activities in just over one fifth (23 per cent).⁸⁰ Approaches that are seldom used are networking (ten per cent) and financing of services (seven per cent).⁸¹

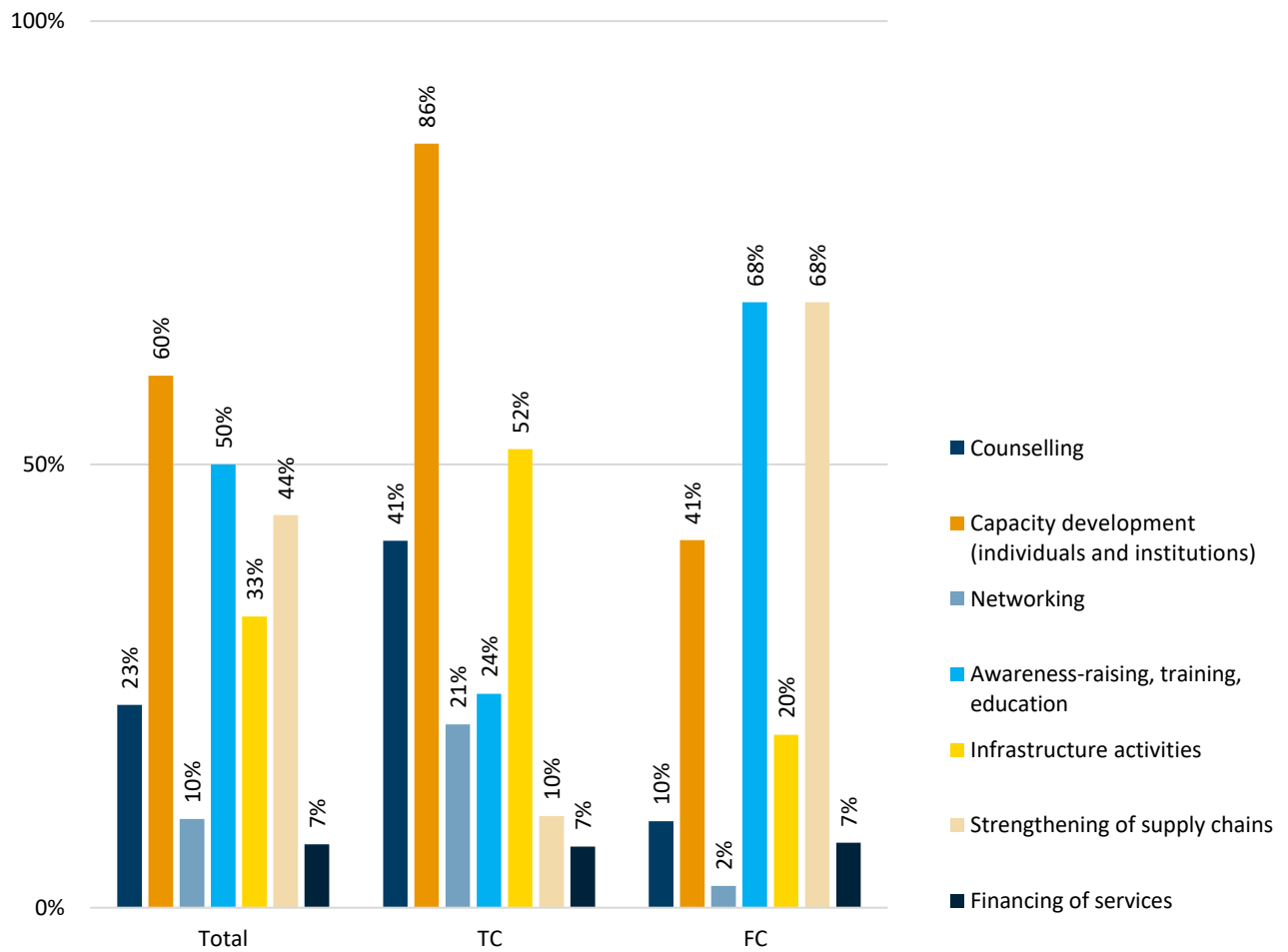
TC and FC interventions differ to some extent in terms of the approaches they use. Sixty-nine per cent of FC interventions pursue their objectives *inter alia* either by strengthening supply chains, or by conducting awareness-raising, training or information and education activities. By comparison, these approaches are used much less frequently in TC interventions, at ten per cent and 24 per cent respectively. TC interventions, on the other hand, focus especially often on capacity development (86 per cent), activities to improve infrastructure and equipment (52 per cent) or advisory services (41 per cent). While infrastructure activities are implemented much less frequently in FC interventions by comparison (20 per cent), the capacity development approach is also often used in FC interventions (42 per cent). The strengthening of networks is an approach that is used more frequently in TC interventions (21 per cent) than in FC interventions (two per cent). No differences can be found in the financing of services (seven per cent each).

⁷⁸ Through training and train-the-trainer activities, interventions that pursue the capacity development approach improve structures, processes and techniques in healthcare facilities, and increase knowledge about the needs of rights-holders. They also improve access to and the quality of HIV-related healthcare services and increase the general competence of staff in healthcare facilities. Interventions that pursue the awareness-raising approach conduct information and education activities and counselling on family planning, the rights of marginalised groups and STIs, including HIV/AIDS.

⁷⁹ Interventions that pursue the approach of strengthening the supply chain aim to increase the supply of contraceptives.

⁸⁰ Interventions that pursue the approach of infrastructure and equipment development support the expansion of healthcare infrastructure as a whole, or the improvement of equipment within healthcare facilities. Interventions that pursue the advisory services approach deliver these services to political decision-makers in order to strengthen policy interventions for SRHR and to improve the availability of population data.

⁸¹ Interventions that pursue the networking approach aim to strengthen the dialogue between healthcare actors. Interventions that pursue the service financing approach aim to integrate SRHR services into national funding systems or make direct financial contributions to rights-holders.

Figure 10 Approaches used by SRHR interventions

Source: DEval's own calculations based on the evaluation synthesis. The chart shows the respective percentage of evaluation reports in which the corresponding approach was mentioned. Since several approaches can be used in a single intervention, the sum of the individual percentage values can exceed 100 per cent (some reports referenced more than one approach). $n_{total}=70$, $n_{FC}=41$, $n_{TC}=29$.

4.3 Effectiveness

4.3.1 Achievement of direct objectives

Summary of findings

Evaluation questions:

- To what extent do bilateral interventions in the SRHR area of intervention achieve their objectives? (EQ 3.1)
- To what extent do bilateral interventions in the SRHR area of intervention contribute to the achievement of objectives regarding the availability of SRH services, their policy environment and financial barriers to access? (EQ 3.2)
- To what extent do bilateral interventions in the SRHR area of intervention contribute to the achievement of objectives regarding the knowledge and attitudes of rights-holders and people in their social environment? (EQ 3.3)

Methods: Evaluation synthesis and case studies.⁸²

Bilateral interventions in the SRHR area of intervention mostly achieve their objectives (EQ 3.1, AC 1).

- In project evaluations, SRHR interventions receive an average effectiveness score of 2.3. The majority of interventions (63 per cent) receive a score of 1 or 2 (indicator 1.1; mostly fulfilled).

Bilateral interventions mostly achieve their objectives regarding the availability of SRH services, their policy environment and financial barriers to access (EQ 3.2, AC 1).

- SRHR interventions contribute to improving the quality, accessibility and availability of SRH services and products as well as to an enabling policy environment for SRHR (indicators 1.1, 1.2 and 1.4; mostly fulfilled).
- SRHR interventions rarely focus on reducing financial and legal barriers to accessing SRH services. The basis for assessment is too small to rate the contribution of German development cooperation (indicator 1.3; no rating).

Bilateral interventions mostly achieve their objectives regarding the knowledge and attitudes of rights-holders and people in their social environment (EQ 3.3, ACs 1, 2 and 3).

- SRHR interventions improve the quality and accessibility of SRHR counselling services and awareness-raising activities (indicator 1.1; mostly fulfilled).
- Knowledge and attitudes towards SRR are improved by contributions from the interventions. Both girls and women as well as people in their social environment are more aware of and accept SRR (indicators 2.1 and 2.2; mostly fulfilled).
- The reduction of gender-discriminatory attitudes is rarely covered by SRHR interventions. The basis for assessment is too small to rate the contribution of German development cooperation (indicator 3.1 and 3.2; no rating).

⁸² The indicators and ACs are rated on the basis of both methods using the scale shown in Annex 8.1. The indicators are rated based on the findings of the evaluation synthesis, as these are representative of all SRHR interventions carried out during the period under review. This assessment based on the evaluation synthesis is then triangulated with the assessment based on the case study findings. In case of major deviations (more than one category difference between the evaluation synthesis and the case studies), the assessment is corrected based on the case study findings. This ensures that the assessments also correspond to current interventions. ACs and EQs are answered based on the average score for all indicators/ACs.

Rating the effectiveness of interventions

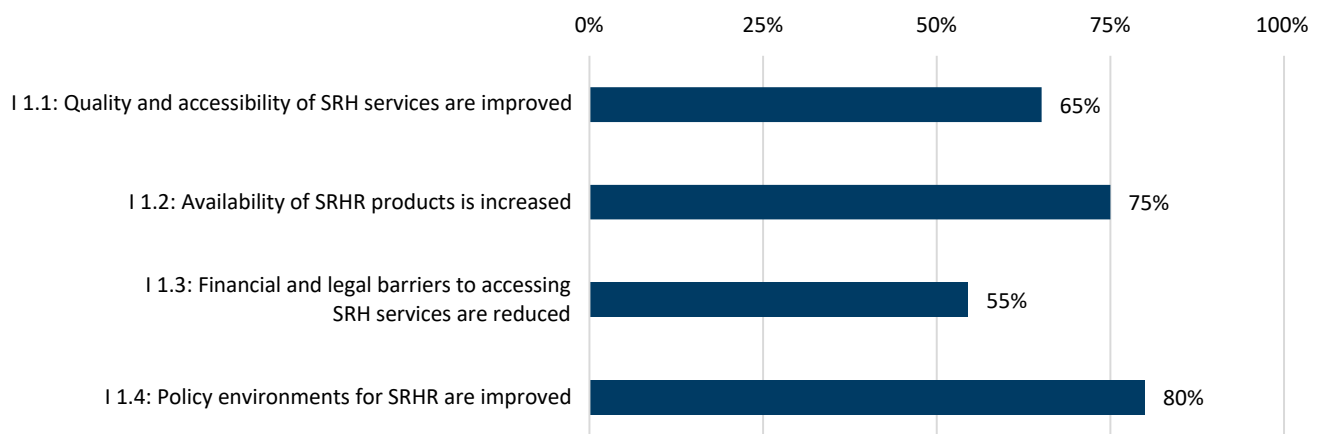
In project evaluations, SRHR interventions are mostly rated as effective. Around half of all evaluated SRHR interventions (35 out of 69 reports) are awarded a score of 2 for effectiveness. A score of 3 was awarded to 30 per cent of all interventions (21 reports). Only a very small number of reports gave interventions a score of 1 (eight reports) or 4 (five reports). The average score for all SRHR interventions in terms of their effectiveness is 2.3 (EQ 3.1, indicator 1.1).

Achievement of direct objectives for SRH

SRHR interventions contribute to improving the quality and accessibility of sexual and reproductive healthcare services

in partner countries. According to their project evaluations, 65 per cent of the interventions (28 out of 43 reports) that aimed to strengthen SRH services achieve this objective (EQ 3.2, indicator 1.1; see Figure 11). Objectives for maternal health and prenatal care (17 reports), the continued training of healthcare personnel needed for that (12 reports) and the strengthening of general reproductive healthcare services for women (11 reports) are particularly common. The findings of the case studies corroborate this finding: in all countries where interventions pursue such objectives, the interviewees state that these objectives are either fully or mostly achieved. These interventions often focus on strengthening maternal and neonatal healthcare and improving the general and preventive use of SRHR services (two case study countries).

Figure 11 Achievement of direct objectives related to SRH (EQ 3.2, AC 1)



Source: DEval's own chart based on findings of the evaluation synthesis ($n_{i1}=43$, $n_{i2}=28$, $n_{i3}=11$, $n_{i4}=15$). The shaded bars are included in the assessment; bars with only a blue border are not included in the analysis of the AC, as the number of cases they involve is less than 20 per cent of all project evaluations examined. The basis for assessment is therefore too small to attribute a contribution to this objective to German development cooperation

According to the project evaluations, SRHR interventions contribute to increasing the availability of SRH products. Improved availability of SRH products is mentioned in 75 per cent of project evaluations (21 out of 28 reports; EQ 3.2, indicator 1.2; see Figure 11). These are mainly contraceptives, especially condoms. Based on the interviews, a positive contribution can also be identified in three out of six case study countries. According to these, financial contributions enable the purchase of contraceptives, for example, while the distribution of condoms by community health workers

increases their availability (three case study countries). At the same time, however, interviewees also report that contraceptives are still only available to a limited extent or not at all (three case study countries).

Few SRHR interventions aim to reduce financial and legal barriers to accessing SRH services. Eleven of the interventions analysed in the evaluation synthesis pursue this objective. Six reports (55 per cent) attest to the effectiveness of the interventions in this regard (EQ 3.2, indicator 1.3;

see Figure 11).⁸³ The analysis of the interviews from the case study countries partially confirms this: according to the interviewees, the reduction of legal barriers is not directly pursued in any of the interventions analysed. The reduction of financial barriers, on the other hand, is pursued directly in four of the six countries and indirectly in the two remaining countries. Examples of such activities include supporting rights-holders in claiming low-cost or free healthcare services (such as medicines, products or treatments; one case study country), some of which are offered for a fee although they should actually be free of charge (two case study countries). Other activities include the distribution of vouchers or support from solidarity funds delivered through mothers' associations that fund medical treatment (five case study countries).

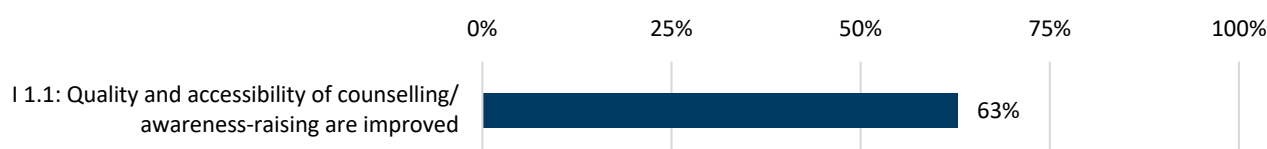
In the partner countries, only few interventions aim to improve the policy environment. According to the project evaluations, this objective is pursued in 15 out of 70 interventions. Of these, 80 per cent (12 reports) are rated as effective (EQ 3.2, indicator 1.4; see Section 4.3.1). The contribution of German development cooperation to the country strategies of the partner countries (ten reports) and the strengthening of civil society (five reports) proved to be particularly effective. The interviews in five of the six case study countries confirm that SRHR interventions make a positive contribution to the formulation of national strategies and to

strengthening decentralised administrative units (including districts, municipalities and villages; five case study countries).

Achievement of direct objectives regarding the knowledge and attitudes of rights-holders and people in their social environment

SRHR interventions contribute to improving the quality and accessibility of SRHR counselling and awareness-raising activities. According to the project evaluations examined, 63 per cent of the interventions (22 out of 35 reports) contribute to improving the quality and accessibility of SRHR counselling services and awareness-raising activities (EQ 3.3, indicator 1.1; see Figure 12). The findings from the case study countries corroborate this. In all the countries studied, the interviews suggest that interventions improve the quality and accessibility of counselling and awareness-raising. Examples of this include the training of healthcare personnel (five case study countries), cooperation with voluntary health workers or associations such as youth clubs (six case study countries) and the provision of information through various media formats and in several languages (five case study countries). This enables specific marginalised groups to be reached (including socio-economically marginalised women and men, young people, people with disabilities and high-risk groups such as sex workers).

Figure 12 Achievement of direct objectives related to counselling (EQ 3.3, AC 1)



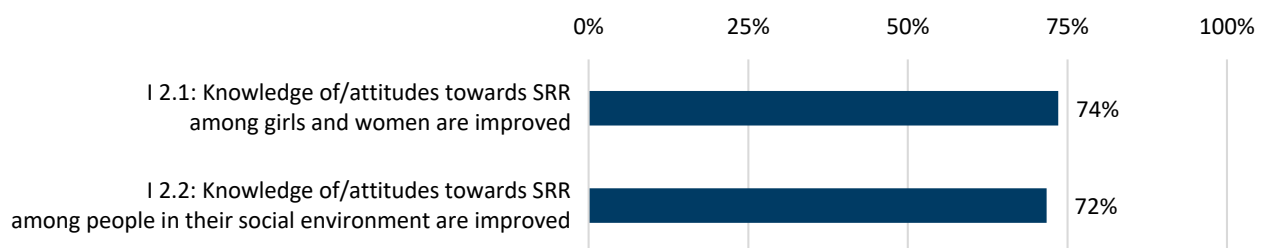
Source: DEval's own chart based on findings of the evaluation synthesis ($n_i=35$).

⁸³ Due to the small number of interventions in which corresponding objectives are pursued, it is not possible to draw any conclusions regarding their effectiveness. Therefore, no score is awarded.

Most of the SRHR interventions examined contribute to changing girls' and women's knowledge on and attitudes towards SRR. The evaluation synthesis concludes that an average of 74 per cent of the interventions pursue the objective of changing the knowledge and attitudes of girls and women (EQ 3.3, indicator 2.1; see Figure 13). It is evident that interventions tend to contribute more to transferring knowledge than to changing attitudes: while a change in knowledge on SRR among girls and women is mentioned in 74 per cent of evaluations (25 out of 34 reports), a change in attitudes towards SRR is mentioned somewhat less frequently at 62 per cent (21 out of 34 reports). This is corroborated by

the case study findings: in five of the six countries examined, the interventions pursue the objective of changing girls' and women's knowledge on and attitudes towards SRR, and achieve corresponding impacts. Interviewees in five countries report that, for instance, knowledge on family planning, prenatal care, skilled birth attendance, risks of early pregnancy, unsafe pregnancy terminations and GBV and harmful practices has improved. Interviewees also report that girls and young women are being made more aware of the risk of early pregnancy (two case study countries). Based on the interviews, however, it is not possible to assess conclusively the extent to which their attitude or behaviour towards these issues has also changed.

Figure 13 Achievement of direct objectives related to SRR (EQ 3.3, AC 2)



Source: DEval's own chart based on findings of the evaluation synthesis ($n_{11}=34$, $n_{12}=46$).

SRHR interventions contribute to people in the social environment of girls and women being familiar with and accepting SRR. According to the evaluation synthesis, 72 per cent of the interventions (33 out of 46 reports) that aim to change knowledge on and attitudes towards SRR in the social environment of girls and women are successful (EQ 3.3, indicator 2.2; see Figure 13). Here too, interventions are less successful in changing attitudes than in strengthening knowledge: according to project evaluations, while 72 per cent of interventions (33 out of 46 reports) have successfully strengthened the SRR-related knowledge of people in the immediate social environment of girls and women, only 50 per cent (23 out of 46 reports) are found to have successfully changed attitudes towards SRR. The interviews also corroborated these findings for four of the six case study countries. In four countries, interviewees reported an increase in knowledge on SRR among girls and women. Indications of changed attitudes were found in two countries. This finding is illustrated by interventions that,

according to the interviews, increase the knowledge of men and boys on responsible sexual behaviour or the use of contraceptives (two case study countries). Interventions are also effective in increasing knowledge on FGM or GBV among traditional or religious authorities (two case study countries). For instance, the interviewees report that including these authorities in the interventions helps to sensitise the population, and especially youth, to SRHR and the use of corresponding services.

Very few SRHR interventions aim to increase knowledge on gender discrimination among girls and women and people in their social environment. The evaluation synthesis identifies only one intervention that aims to change discriminatory attitudes among girls and women (EQ 3.3, indicator 3.1) and four interventions that focus on people in their social environment (EQ 3.3, indicator 3.2). Four of these five evaluations suggest that knowledge on gender discrimination has improved among girls, women and people in their social environment.

Successful approaches involve the inclusion of men (two reports), a culturally sensitive orientation of the interventions (one report) and dissemination through mass media (one report). The interviewees in the case study countries also do not focus explicitly on knowledge of gender discrimination. Only in two countries is an improvement in the knowledge of girls and women reported, while no change is mentioned in four other countries. For the people in their social environment, the information on changes is even less clear: the interviews

in two countries demonstrate that SRHR interventions increase knowledge on gender discrimination among men and so-called gatekeepers such as parents or traditional and religious authorities, but that a traditional understanding of gender roles still prevails, which makes changes in behaviour more difficult (see Box 6). Given the small number of reports on these two indicators, and the imprecise information from the interviews on the effectiveness of the interventions, this indicator is not rated.

Box 6 Voices of rights-holders – gender transformation and the role of men

Sexual and reproductive health and rights require a standardised approach that includes women and men. The interviews with rights-holders in Malawi and Togo demonstrate that gender norms and roles, and how they are perceived, are responsible for the still low acceptance among men for sexual and reproductive health and rights services, especially family planning:

- *“Most men are against women using family planning services.”* (ID 51)
- *“We boys think that our masculinity is weakened when a woman uses these family planning methods.”* (ID 36)
- *“Some men do not agree with birth control. We have been educated about the various family planning methods. Some women have refused to attend the awareness-raising sessions, others have been prevented from attending by their husbands.”* (ID 102)
- *“We have volunteers in the villages who educate people about family planning, but the problem is the husbands. In the villages, many men deny their wives access to these services.”* (ID 45)

According to the interviewees, educating women is not enough to change traditional norms and practices that have a negative effect on the sexual and reproductive health and rights of women, men and youth. In Togo, the health programme involves men who act as role models (model fathers – papa champions) in their communities and convey a different image of men's role and responsibility in the family:

- *“You see the papa champion who isn't violent in the home, who often accompanies his wife to hospital when a child is ill and who tries to make sure it gets treated there. Then you notice differences between his household and those of the neighbours. People are beginning to understand, but because of the weight of traditions and customs, things are not moving quickly.”* (ID 85)
- *“There used to be a lot of men who resisted family planning, but now there are men who accompany their wives to hospital for it.”* (ID 92)
- *“We didn't used to talk to our wives. Now we talk to each other, and through these conversations we have also managed to get our children to behave differently.”* (ID 107)
- *“In the past, when you had children, you said that the girl shouldn't do the boy's work and the boy shouldn't do the girl's work. A boy used to say that's girl's work and you should leave him alone. Now the men have understood that whether you're a boy or a girl, you should help out and do the work.”* (ID 107)

Effectiveness of interventions for marginalised groups

Constraints on the effectiveness of SRHR interventions exist above all for youth and unmarried people. According to the interviews in the case study countries, there are barriers to accessing SRHR services for these two groups in particular (four case study countries). Interviewees mentioned the shame of visiting healthcare facilities and the fear of being reprimanded by healthcare staff if they seek information on contraceptives, for example (two case study countries). They experience stigmatisation and discrimination based on social norms from

both the healthcare personnel and their social environment (including their parents), which denies or prohibits them access to SRH services (four case study countries). These constraints can often only be partially overcome despite the fact that SRHR interventions target youth. Accordingly, these rights-holders cite a lack of youth-specific services (two case study countries; see also Box 7). At the same time, interviewees also reference the importance of people in their social environment who act as gatekeepers. Parents or traditional and religious authorities, for example, can motivate youth to request SRHR services (one case study country).

Box 7 Voices of rights-holders – youth-friendly services

Youth, especially girls, are marginalised groups in most societies of German development cooperation's partner countries.

In Malawi and Togo, they are also marginalised in terms of access to sexual and reproductive healthcare services, as they themselves reported in the interviews. Many youth are ashamed to request contraceptives in public healthcare facilities, for fear of meeting relatives there, for instance. Low-threshold, youth-friendly services that cater to their needs for confidential information and impartial counselling are rare. Youth from both countries report that they do not feel that healthcare staff take their needs seriously:

- *“When a relative works at the healthcare centre, it becomes difficult to obtain contraceptives. We are afraid that they will insult us. Also, these healthcare workers are older than us, so we become shy.”* (ID 43)
- *“When youngsters like us go to hospital to get contraceptives, the doctors sometimes refuse to help us. They say we're too young.”* (ID 37)
- *“They ask us if we have a husband, so we just lie and say we are married.”* (ID 41)
- *“We girls get turned away on the grounds that we have never had a child and should therefore give birth first before we get the contraceptives.”* (ID 37)
- *“They believe that we want the contraceptives in order to prostitute ourselves.”* (ID 37)

The youth interviewed in both countries state that unintended and early pregnancies are still a frequent occurrence because they do not know how to protect themselves. They are rarely able to talk to their parents about sexuality:

- *“Many of our friends give in to boys very early on and get pregnant because they don't know much about prevention. They then try to have the pregnancy terminated.”* (ID 98)
- *“Our mothers and fathers don't want to talk to us about sexuality.”* (ID 106)
- *“When we go home, we are told not to go along with the things we learned at the club. And there are conflicts between parents and youth.”* (ID 49)

Youth look to their peers and social networks for answers to their questions:

- *“My brother's daughter knows how to take care of herself [...]. I've seen it on her mobile phone. She has girlfriends who send her information on contraception and show her how to do it.”* (ID 106)

In both countries, the health interventions support peer-to-peer approaches to inform and educate youth. In Togo, young mothers who have unintentionally become pregnant educate other girls and young women. Interviewees state that interventions in Togo and Malawi support school and youth clubs:

- *“We make other girls more aware of family planning, risky births and the consequences of pregnancy terminations, gender-based physical and emotional violence, contraceptives and condoms, and about breastfeeding and caring for a child. We do a lot of educational work on family planning because mothers don't talk to their daughters about sexuality.”* (ID 108)
- *“We have youth clubs where we discuss these matters, unlike with our parents.”* (ID 43)

They add that one important prerequisite for the success of the youth clubs is acceptance by parents and the community:

- *“In the past, our parents did not allow us to attend youth groups because they thought we would teach each other about prostitution. But over the years they have learned how important youth clubs are, and now they encourage us to attend because we learn how to protect ourselves from things they're afraid to talk about.”* (ID 48)
- *“Our mothers never talked to us about sexuality, but today, thanks to sexuality education, some parents can talk to their children about it.”* (ID 108)

Marginalised population groups, such as poor people in remote rural regions, can be reached primarily through outreach and awareness-raising activities. Interviewees mention the challenges faced by these groups of people, such as long distances to the nearest healthcare facility (six case study countries). Outreach activities include traditional health information events such as roadshows, educational brochures in national languages and other interpersonal communication approaches that help to contain existing gender-based marginalisation and misinformation and thus improve access to SRHR information. Awareness-raising activities can also help to inform marginalised groups about their rights and about gender equality in general. According to the interviewees, community health workers and volunteer health workers, for example, carry out home visits to inform women of their rights, or they create WhatsApp groups between peers to provide information on self-determination, and on antenatal care for women (two case study countries). According to the project evaluations, however, interventions often failed because the information disseminated was not sufficient or women did not or could not change their behaviour even with new knowledge, as the associated costs or religious reasons or fears prevented them from doing so.⁸⁴

Unintended negative effects

Unintended negative effects are mentioned occasionally in the project evaluations analysed. . Thirty per cent of the project evaluations addressed possible unintended negative effects (21 out of 70 reports); only three reports identified such effects. For example, one intervention in which new healthcare facilities are being opened for pregnant women who have fled their homes led to an increased need for blood transfusions. However, this demand is not being adequately met as there are no safe stocks of blood reserves anywhere in the country. This is having a negative effect on the care of other patients (doc xxi).

The case studies also show no indications of systematic unintended negative effects caused by bilateral interventions.

The interviews contain only a few references to possible unintended effects of the interventions. In two of the six countries, interviewees referenced possible normative conflicts resulting from activities. For example, the increased demand among young people or women for modern contraceptives is associated with an increase in intra-family conflicts, as parents or husbands fear that their children or wives will be encouraged to engage in increased sexual behaviour. SRHR interventions also have a negative effect on the structure

⁸⁴ No information is available in evaluation reports on other marginalised groups (see Section 4.1).

of healthcare provision in a few cases. In some interviews, respondents report that interventions in which healthcare personnel receive training or capacity development support contribute to the trained personnel leaving the often less

attractive places of work or even migrating abroad. However, trained staff are needed in remote rural regions in particular (two case study countries).

4.3.2 Factors influencing the achievement of direct objectives

Summary of findings

Evaluation question: What factors enable or constrain interventions in achieving their direct objectives? (EQ 3.4)

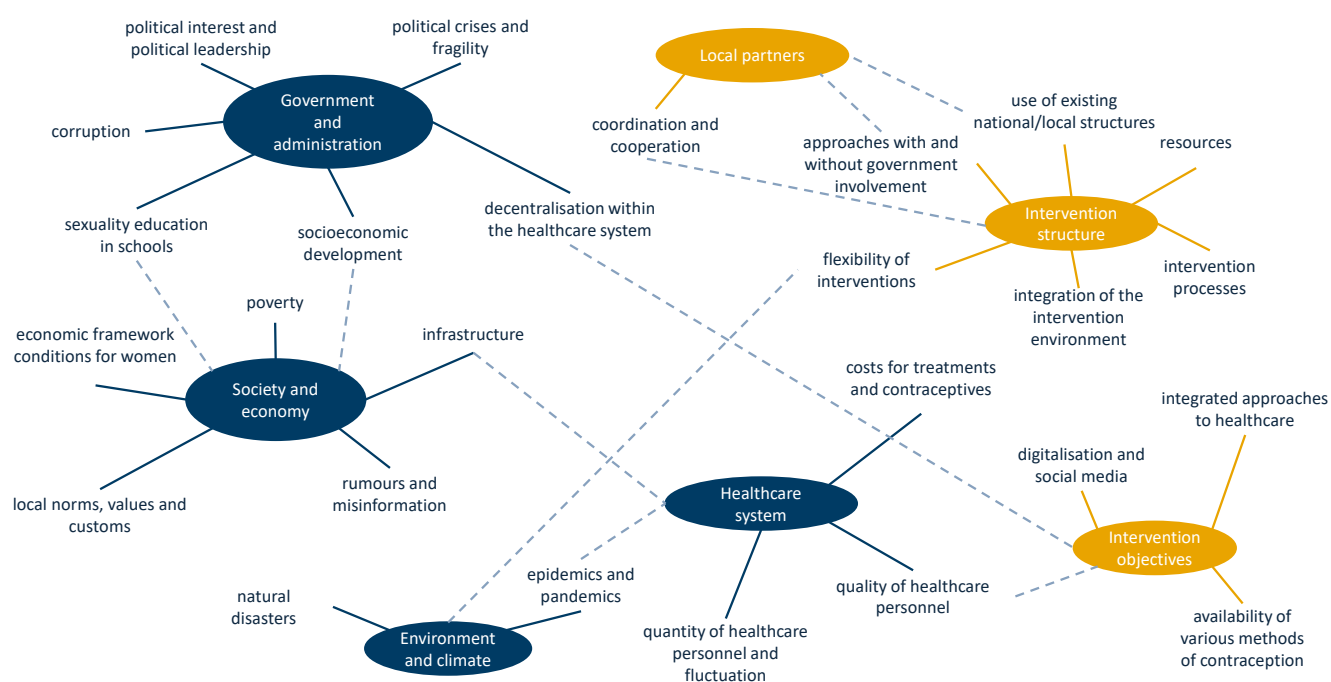
Methods: Evaluation synthesis and case studies.

The effectiveness of interventions is affected by factors at country context level and at intervention level.

- The effectiveness of interventions depends on the socio-economic development status and political fragility of a partner country. However, awareness-raising activities and the strengthening of supply chains also prove to be effective regardless of the country context.
- At the level of national and local conditions, it is primarily state and social structures that affect the population's access to and demand for SRHR. To bring about change, political interest and the interest of society as a whole are required. At the same time, shortcomings in the healthcare system or environmental influences can constrain the achievement of the objectives of SRHR interventions.
- At intervention level there are opportunities to align the structure and objectives with country needs. Cooperation with development partners and local structures can have a positive impact on the effectiveness of SRHR interventions.

Factors influencing the achievement of direct objectives can be categorised into two levels: national and local level, and intervention level. Factors at the level of national and local conditions affect the social structure and the lives of rights-holders. They are beyond the influence of development

cooperation, but can be addressed through its interventions. The factors at intervention level are structural approaches and objectives of German development cooperation that prove to have an enabling or constraining effect in the course of implementation (see Figure 14).

Figure 14 Enabling and constraining factors influencing the achievement of direct objectives

Source: DEval's own diagram based on findings of the evaluation synthesis and the case study countries. Factors affecting national and local frameworks are shown in blue and factors at intervention level in yellow. The solid lines indicate a direct relationship between the factors and the thematic area, while the dotted lines indicate an indirect relationship with other thematic areas.

Factors influencing national and local conditions

The country context⁸⁵ usually influences the effectiveness of the various approaches significantly. The analysis of project evaluations shows that SRHR interventions are more effective in countries with a higher Human Development Index (HDI) than in countries with a lower HDI. In particular, interventions that focus inter alia on capacity building and strengthening supply chains and infrastructure are rated better on average in countries with a higher HDI than in other countries. By contrast, the effectiveness of interventions that focus inter alia on awareness-raising activities varies to a lesser degree in different contexts (see online annex).⁸⁶ Furthermore, lower fragility in the

partner countries has a positive influence on the effectiveness of the various approaches.

These influencing factors are corroborated by the case study findings. Based on the interviews, the following factors were identified as affecting the success of interventions.

- **The state and the administration as partners for change.** In the case studies, the state is mentioned as a central factor in achieving the objectives. Above all, the interest of state partners at national and local level in taking a leading role in the implementation of SRHR is

⁸⁵ The country context is defined in terms of a country's Human Development Index (HDI) and its fragility. The HDI includes life expectancy, literacy and education rates as well as gross national income per capita. The scale ranges from 0 (low level of human development) to 1 (very high level of human development). The threshold value for the evaluation was set at 0.50, as only few partner countries have a medium to very high level of human development. The fragility of a country was assessed for the evaluation synthesis using the Fragile States Index. This index comprises indicators that cover social cohesion as well as economic, political and social fragility. It ranges from 0 (low fragility) to 120 (high fragility), and was dichotomised for the analysis of the evaluation synthesis. The threshold value was set at 82.3 based on the median.

⁸⁶ The mean difference for infrastructure activities is 0.62, for capacity development 0.37, for strengthening supply chains 0.37 and for awareness-raising activities 0.19. Only those approaches were included here for which the number of interventions was large enough for group comparisons.

described in interviews as a significant factor (five case study countries). For example, national legislation is cited as an important enabling condition (three case study countries). Conversely, the lack of interest on the part of state actors has a negative impact on the effectiveness of SRHR interventions. For example, restrictions on sexuality education in schools were identified in the interviews as a constraining factor for the success of SRHR interventions, such as when sexuality education is not compulsory in schools or certain topics are not addressed because school staff are not sufficiently qualified to do so (one case study country). Political corruption, political crises and fragility were also identified as constraining factors (four case study countries). In one country, the decentralisation of public administration was named as an enabling factor. According to this respondent, a decentralised structure enables healthcare facilities to select and hire their own staff, for example.

- **Society and the economy as the source of demand for SRHR services and products.** In all six case study countries, local norms, values and customs were cited as the greatest challenge to achieving the objectives and effectiveness of the interventions. This also includes highly religious views (four case study countries). These factors affect inter alia which groups have access to SRHR services, or which activities can be implemented as part of interventions. Social media, which can be used to spread rumours and misinformation, also play an important role here (two case study countries);⁸⁷ according to the interviewees, attitudes towards SRHR are often shaped by misinformation (two case study countries). Improved economic conditions for women are also cited as a positive factor (one case study country). On the other hand, poverty, particularly among women, has a negative effect on the achievement of objectives, as the women concerned continue to experience discrimination despite having access to SRHR services. Very poor population groups have inferior access to healthcare services or are given lower priority (three case study countries). Furthermore, the interviewees reference the lack of transport infrastructure (such as

roads or patient transport; five case study countries); this results in higher costs for health visits and makes access to healthcare facilities more difficult, especially for very poor population groups (four case study countries).

- **The environment as a competitor for resources.** According to the interviewees, epidemic and pandemic outbreaks lead to SRHR interventions having to be partially cancelled or rescheduled (one case study country); German development cooperation shows a high degree of flexibility in such situations and adapts its interventions to the changed needs (three case study countries).⁸⁸ However, no mention is made of whether other activities are cancelled due to the redistribution of funds. The interventions also adapt to some extent in the event of natural disasters (one case study country). In two cases, the interviewees report that natural disasters affect the effectiveness of interventions. Prolonged periods of drought, extreme rainfall or intense heat have a negative effect on the health of the population and lead to healthcare facilities being overstretched (one case study country). Moreover, poverty is on the rise, meaning that poverty-related challenges in the area of SRHR are also increasing (one case study country). For example, interviews refer to transactional sexual relationships, such as precarious life circumstances leading girls and young women to offer sexual services in return for benefits (two case study countries).
- **The health sector as an implementation partner.** The healthcare system in the case study countries is described not only as an addressee, but also as a factor influencing the achievement of the objectives of SRHR interventions. Accordingly, poorly trained healthcare personnel constrain the improvement of SRHR (one case study country). Discriminatory behaviour by healthcare personnel, known as provider bias, also prevents the use of SRHR services, particularly by youth, but also by other marginalised groups such as LGBTI people (four case study countries). For example, interviewees report that youth often meet with a lack of understanding when they seek information on contraceptives (two case study countries).

⁸⁷ Communication through social media is an important promotional tool that enables interventions to reach people who either cannot be reached via other media at all or who can be reached only to a limited extent (see the factors at intervention level).

⁸⁸ In the interviews, the interviewees rated this flexibility of the interventions positively. However, this entails the risk that human or financial resources are reallocated within interventions and are therefore no longer available to achieve the original objectives.

Interviewees state that healthcare facilities are not geared towards the specific needs of certain groups such as youth. For example, they feel that they do not receive age-appropriate counselling, or fear social stigmatisation if they are recognised by relatives or neighbours when visiting healthcare facilities or counselling centres (three case study countries). Furthermore, the success of interventions is also constrained by a lack of healthcare staff. For example, interviewees state that difficult working conditions lead to a higher turnover of healthcare personnel who participate in training programmes, but then often move to cities or abroad after doing so (four case study countries).

Influencing factors at the level of interventions

Furthermore, influencing factors can be identified at intervention level.

- Alignment with existing structures and available resources.** Not only external circumstances, but also the intervention-specific structures affect the effectiveness of SRHR interventions. For example, interviewees report a lack of human and financial resources to implement interventions in line with their planned objectives (two case study countries). Access to sufficient financial resources is thus cited as a positive factor. Furthermore, long and complex processes reduce the effectiveness of interventions because they require plenty of human resources and interventions have to be interrupted regularly (one case study country). Interviewees also states that non-governmental approaches, such as those used in fragile contexts, can make changes at political level more difficult, as development policy dialogue with the partner-country government may not take place (one case study country). While cooperation with state structures is described as important for the effectiveness and sustainability of interventions, interviewees also draw attention to the importance of cooperation with local structures. For example, it is important to integrate interventions into existing social structures and local administrative structures. This also includes involving community health workers (two case study countries), which can also be conducive to the sustainability of development cooperation interventions (see also Section 4.6).
- Pursuit of target group-specific intervention objectives.** The case study findings show that integrated approaches can have a positive impact on the effectiveness of SRHR interventions. For example, in some case study countries, the combination of vaccination campaigns with information campaigns on contraception and the combination of health services with SRHR-specific youth counselling is emphasised (four case study countries). This has made it possible to reach groups of people who might not otherwise have participated in SRHR campaigns. The use of different media also creates a low-threshold approach that can be used to reach diverse groups of people. For example, interviewees point to the importance of digitalisation and increasing access to social media, which allows development cooperation interventions to reach more youth with information on SRHR (two case study countries). At the same time, however, youth awareness needs to be raised so that youth are able to distinguish between rumours or false information on the one hand, and valuable experiences and information on the other. For example, knowledge about the health risks associated with the use of various contraceptives is communicated through different channels. However, interviewees report that a corresponding lack of target group-sensitive selection of contraceptives can limit the effectiveness of interventions (two case study countries). This influencing factor becomes even more important in view of the misinformation mentioned above: much of the misinformation discussed in the interviews relates to the supposed effects of contraceptives (two case study countries), and in particular – but not exclusively – to long-term contraceptives (two case study countries).
- Overarching cooperation with local partners.** Both joint consultation and cooperation with various local partners are described in the case studies as a positive factor for achieving the objectives. Examples of this include cooperation with national governments (e.g. ministries of health), multilateral and national organisations, municipalities and individuals. According to the interviewees, this cooperation has simplified the implementation of interventions (two case study countries).

4.4 Impact

Summary of findings

Evaluation question: To what extent do interventions in the SRHR area of intervention contribute to empowering rights-holders and structurally marginalised groups with regard to their SRHR? (EQ 4.1)

Methods: Evaluation synthesis, case studies and secondary data analysis.⁸⁹

Bilateral German development cooperation interventions are rated as mostly effective (AC 1).

- In project evaluations, SRHR interventions receive an average score of 2.5. The majority of interventions (49 per cent) receive a score of 3 (indicator 1.1; mostly fulfilled).

The strengthening of girls' and women's self-determination with regard to SRHR is mostly achieved (AC 2).

- SRHR interventions mostly contribute to girls and women feeling empowered to make self-determined decisions about their bodies, their sexuality and their reproduction (indicator 2.1; mostly fulfilled).
- Only very few interventions pursue the objective of reducing GBV and harmful practices. The basis for assessment is too small to assess the contribution of German development cooperation (indicator 2.2; no rating).
- German development cooperation contributes to improving gender equality. However, the successes are highly context-dependent and only partially contribute to changes in behaviour (indicator 2.3; partially fulfilled).

Strengthening the right to SRH is mostly achieved (AC 3).

- Maternal and neonatal mortality rates have fallen in partner countries over the last ten years, although significant differences are evident depending on the country and year. SRHR interventions contribute to this (indicator 3.1; mostly fulfilled).
- Unintended and early pregnancies among girls and young women are a challenge in the partner countries of German development cooperation. SRHR interventions partially contribute to reducing these (indicator 3.2; partially fulfilled).

The impact of interventions

SRHR interventions mostly contribute to the empowerment of rights-holders and structurally marginalised groups. Based on the findings of the evaluation synthesis, almost half of all SRHR interventions are rated 3 for impact (34 out of 69 reports). A further 39 per cent of all interventions (27 reports) are rated 2. Only five reports award a score of 1, two reports a score of 4 and one report a score of 5. SRHR interventions thus receive an average score of 2.5 for impact (indicator 1.1).

The factors that influence the impact of interventions are the same as those that influence their effectiveness, according to the interviews (see Section 4.3.2). They can be divided into factors influencing national and local conditions (government and administration, society and the economy, the environment and the healthcare system) and those at the level of interventions (intervention structure, intervention objectives and local partners).

⁸⁹ The indicators and ACs are rated on the basis of both methods using the scale shown in Annex 8.1. The indicators are rated based on the evaluation synthesis findings, as these are representative of all SRHR interventions carried out during the period under review. This assessment based on the evaluation synthesis is then triangulated with the assessment based on the case study findings. This means that in case of major deviations (more than one category difference between the evaluation synthesis and the case studies), the assessment is corrected based on the case study findings. This ensures that the assessments also correspond to current interventions. The findings of the secondary data analysis are not taken into account in the assessment, as it is not possible to causally attribute changes to development cooperation contributions. ACs and EQs are answered based on the average score for all indicators/ACs.

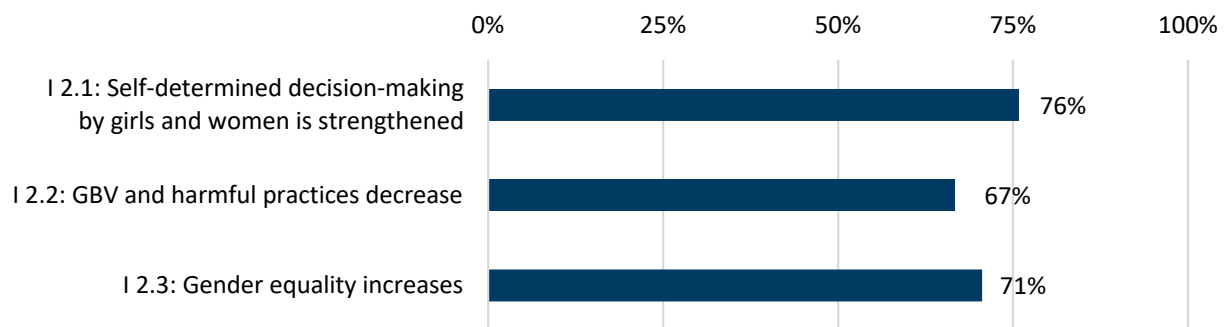
According to the project evaluations, impacts are most often achieved in SRHR interventions that pursue combined approaches. Interventions that combine activities for access to SRHR services, capacity building for healthcare personnel and improving the legal situation in the partner country are rated best. Interventions that combine infrastructure activities with activities to build the capacity of institutions, individuals and organisations are also rated as more impactful than interventions which use other combinations.

Strengthening the self-determination of girls and women

SRHR interventions mostly contribute to girls and women feeling empowered to make self-determined decisions about their bodies, their sexuality and their reproduction. This applies to 76 per cent of the interventions in the project evaluations (indicator 2.1; see Figure 15). This is made clear by the fact that girls and women above all make more conscious decisions to use contraceptives (14 reports). Other impacts are achieved less frequently. These include the decline in high fertility rates – over five children per woman⁹⁰ – (four reports), the strengthening of self-determined family planning (three reports) or the reduction in teenage pregnancies (three reports). The positive contribution of German

development cooperation is not corroborated by the interviews in the case study countries. Interviews in two of the six countries suggest that more girls and women are making self-determined decisions than was the case five to ten years ago. However, these decisions are still limited when it comes to their own bodies (see Box 8). For example, interviewees mention that contraceptives are increasingly available (one case study country), but that not all rights-holders are equally able to request and use them (two case study countries; see also the sections on marginalised groups in Section 4.1.1 and Section 4.3.1). The DHS data also indicates that the use of modern contraceptives in the partner countries of German development cooperation increased overall between 2011 and 2022, but only slowly (and in some countries not at all). It also varies from partner country to partner country. For example, nine per cent of women of reproductive age (15 to 49 years) in the Democratic Republic of the Congo use at least one modern means of contraception (DHS data from 2013), compared to 64 per cent in Colombia (DHS data from 2015; see online annex). The results of the secondary data analysis show that there is no statistical relationship between the use of modern contraceptives and German ODA disbursements for SRHR (see Figure 16). This applies both to the logarithmic values of ODA disbursements and to ODA disbursements relative to the gross domestic product (GDP) of the partner country.

⁹⁰ The fertility rate per woman is categorised as high if she has five or more children. High fertility is associated with an increased risk of maternal mortality, a high number of unintended and early pregnancies, child marriages and rapid population growth (see https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/undesapd_2021_wpp-fertility_policies.pdf, accessed on 27 January 2025).

Figure 15 Achievement of higher-level targets for the strengthening of self-determination (AC 1)

Source: DEval's own chart based on findings of the evaluation synthesis ($n_{11}=29$, $n_{12}=6$, $n_{13}=17$). The shaded bars are included in the assessment; bars with only a blue border are not included in the assessment, as the number of cases they involve is less than 20 per cent of all project evaluations examined.

Box 8 Voices of rights-holders – strengthening the self-determination of girls

In Malawi and Togo, poverty, patriarchal norms and harmful practices constrain the right to self-determination and the room for action of girls and women. Girls and young women are particularly marginalised on the grounds of their gender and age, and in some cases experience multiple forms of discrimination, for instance due to pregnancy and resulting forced marriage:

- “When a girl gets pregnant, the parents arrange the marriage to avoid disgracing the family in the community. The girls who want to continue their education or studies try to terminate the pregnancy secretly using traditional methods.” (ID 108)

Rights-holders also report that parents do not fulfil their duty of care and that from a certain age onwards girls have to fend for themselves. This pushes them into risky relationships:

- “At the age of twelve, your parents tell you that you are old enough to support yourself. If you have no money, you give yourself to a man so that he gives you money.” (ID 104)
- “Our parents tell us we are adults and we should start looking after ourselves, so we are forced to find old men to help us financially. In return, we offer them sex.” (ID 43)
- “You are also forced to marry so that your parents get the bride-price.” (ID 43)

However, girls and women are also increasingly aware of their rights:

- “Now when a girl gives birth to a child, she fights in order not to become dependent on the man.” (ID 103)
- “Girls used to be ashamed to come to school pregnant, but thanks to awareness-raising, pregnant girls now continue to go to school.” (ID 103)
- “I have a right to my body, it's nobody else's business.” (ID 51)

Only very few SRHR interventions contribute at the level of impact to reducing GBV and harmful practices in partner countries. In the evaluation synthesis, only six out of 70 interventions were identified that aimed to make

a corresponding contribution. The basis for assessment is therefore too small to attribute a contribution to this target to German development cooperation (indicator 2.2; see Figure 15). However, interviews in three out of six case study countries

do contain statements regarding an active contribution by German development cooperation to combating GBV and harmful practices (as illustrated in Box 9). According to these, German development cooperation contributes to effectively raising public awareness of this issue through corresponding campaigns and support from community health workers or peers (three case study countries), and to effectively providing women with psychosocial support if they are victims of violence (three case study countries). According to interviewees, awareness-raising activities can increase people's awareness of GBV and their openness to talk about it. Respondents also report that affected persons feel empowered to report GBV, as perpetrators increasingly face condemnation (one case study country). However, these isolated examples of German impacts are not reflected at national level. While the DHS data shows that the proportion

of women in the partner countries examined who consider violence a tolerable response to their refusal of unwanted sexual activity decreased between 2011 and 2022, the figures vary widely between countries: between one per cent of all women of reproductive age (15 to 49 years) in Colombia (DHS data from 2015) and 52 per cent of all such women in Niger (DHS data from 2012) tolerate violence as a response to their refusal of unwanted sexual activity (see online annex). For underage respondents (under the age of 18), there is a statistically significant, positive correlation between the indicator for the rejection of violence in unwanted sexual acts and German ODA disbursements for SRHR (see online annex). This applies both to logarithmic ODA disbursements and to ODA disbursements relative to the gross domestic product (GDP) of the partner country. There is no such correlation for the respondents as a whole (see Figure 16).

Box 9 Voices of rights-holders – gender-based violence

More girls and women know their rights than five to ten years ago; however, social norms and values make it difficult for them to also realise these rights. According to the interviewees in Malawi and Togo, gender-based violence is widespread in both countries. Physical and psychological violence against girls and women, sexual harassment and rape usually take place in the family and neighbourhood, at school or in educational institutions. The underlying structural causes are social norms, traditional role models and power structures, or excessive alcohol consumption. These often lead to violence being perpetrated against children and women:

- *“When women go to a funeral, they come home late. Their husbands are at home waiting for them. If the women haven't prepared anything to eat, the fights start.”* (ID 92)
- *“Sometimes men think that women are their property, so they do what they want with them. If the woman wants to talk, the man says he is the master of the house, so there is violence.”* (ID 91)
- *“Sometimes we as women are sexually harassed in our marriages, so we can't claim that we have a 100 per cent say when it comes to our bodies.”* (ID 51)

In Togo, the health programme has integrated gender-based violence into its educational and further training activities. The rights-holders state that more cases of sexual violence have been reported since then. However, power structures within the family often prevent victims from receiving psychosocial care and support:

- *“Sometimes the victim herself hesitates to report the rapist. If it is a family member who has raped the girl, she is stigmatised by her parents. This is what discourages them.”* (ID 91)
- *“When children are raped, some mothers hide it, others don't want to tell, but some do go to the police.”* (ID 102)

In partner countries, German development cooperation is committed to sensitising girls and women and those in their social environment to harmful practices, for example by raising awareness in local communities that physical and sexual violence against girls and women is a violation of their rights. This also includes stopping norms and traditional rites that violate human rights when girls and boys reach puberty. Such practices are increasingly being stopped, as the interviewed rights-holders report:

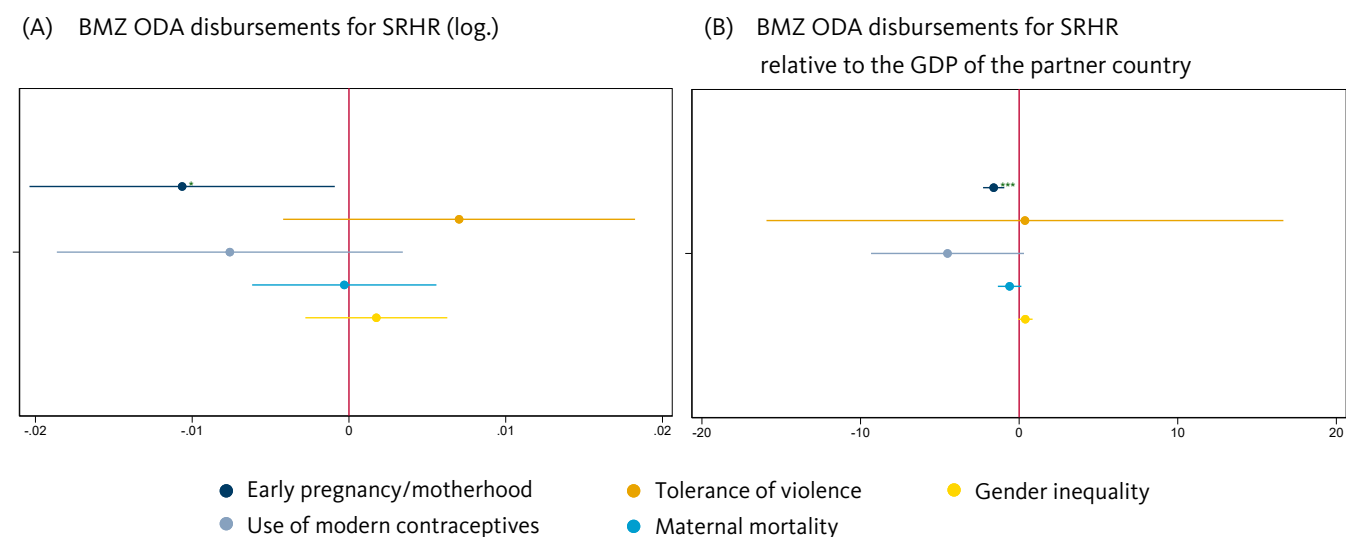
- *“If your husband beats you and you report it to the police, these days you get support, whereas in the past they could just tell you to go and sort it out on your own, it's a family matter, it's none of our business.”* (ID 51)
- *“Traditionally, when a girl started menstruating, many villagers would come to counsel the child. Nowadays, when a girl starts menstruating, she is counselled by her aunt, who helps her deal with it.”* (ID 45)

According to project evaluations, SRHR interventions in the partner countries were mostly able to contribute to gender equality. This is confirmed for 71 per cent of the interventions (12 out of 17 reports; indicator 2.3; see Figure 15). Positive changes are primarily achieved through improved access to education and information (five reports) and the increased recognition of gender equality by men (five reports). The latter is also corroborated by the interviews from four case study countries. According to these, awareness-raising activities by German development cooperation have contributed, among other things, to women having more decision-making rights on SRHR and to men reflecting more strongly on their own role and behaviour and becoming more involved in SRHR-specific topics (two case study countries). However, such contributions are highly context-dependent. For example, interviewees in

two other case study countries report setbacks in gender equality, and in three countries report continuing constraints on gender equality. The findings from the evaluation synthesis and the case studies demonstrate that there is still a need for activities in this area. This is also corroborated by the secondary data analysis. The analysis of the Gender Inequality Index (GII)⁹¹ shows that in the partner countries of German development cooperation examined, there were barely any changes in gender equality between 2011 and 2022 (see online annex). However, there are also significant differences here. For example, the UNDP data for 2021 shows a range of GII scores from 0.285 for Tajikistan (indicating low gender inequality) to 0.820 for Yemen (indicating high gender inequality). The analysis of the secondary data for the GII indicates no statistical relationship with German ODA disbursements for SRHR (see Figure 16).

⁹¹ The GII combines information from the areas of health (maternal mortality and early pregnancies), empowerment (proportion of women/men in the population with secondary education or higher, proportion of women/men in parliament) and the labour market (labour market participation of women/men) in one index. The index ranges from 0 (low gender inequality) to 1 (high gender inequality) and is calculated per country. More information on the GII and the other SRHR indicators can be found in the online annex.

Figure 16 Findings of the multivariate regression analysis on the relationship between BMZ ODA disbursements for SRHR and SRHR target indicators for data from 2011 to 2022⁹²



Source: DEval's own chart, based on DHS, World Bank and UNDP data. The target indicators have been standardised for uniform presentation and better readability. The standardised values are shown on the y-axis. A deviation from the null value of the standardised values indicates a statistically significant relationship, if the confidence intervals do not cross the null value. A negative deviation points to a reduction in relation to the selected SRHR indicator, while a positive deviation points to an increase. The relationship between both the ODA disbursements and the control variables on the one hand, and the SRHR target indicators on the other, is shown with a one-year lag. The findings take into account all control variables and, depending on the data set, country and/or year fixed effects. Asterisks indicate the level of significance of the estimate (*=10 per cent, **=5 per cent, ***=1 per cent), 90 per cent confidence interval.

Strengthening the right to SRH

SRHR interventions contribute to reducing maternal and neonatal mortality in the partner countries. According to the project evaluations, German development cooperation achieves the target of reducing maternal and neonatal mortality in 68 per cent of interventions (19 out of 28 reports) (indicator 3.1; see Figure 17). Activities aimed at improving maternal health and prenatal care are cited as the most important factors in achieving this reduction. These include upskilling healthcare personnel (14 reports) and developing institutional capacities (ten reports). The case study countries corroborate these findings. In three of the six countries, a reduction in maternal and neonatal mortality is mentioned in interviews.

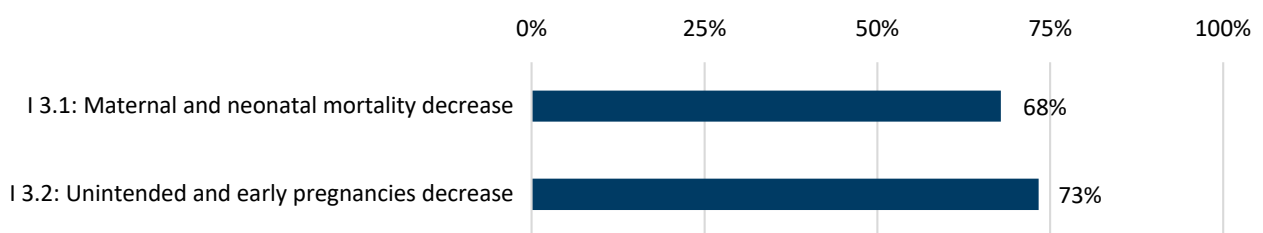
At a higher level, the interventions analysed aim to create incentives for fewer home births and more births in healthcare facilities with trained staff (two case study countries). The aim is also to increase birth spacing and thus allow mothers longer recovery periods (two case study countries). The analysis of secondary data from 2011 to 2022 confirms that the maternal mortality ratio (MMR, measured in the number of deaths per 100,000 births) fell in all partner countries of German development cooperation (see online annex). However, the extent of reduction varies greatly between countries (from MMR=50 in Tajikistan to MMR=1,047 in Nigeria, World Bank data from 2020) and over the years (see online annex).

⁹² A statistical relationship exists when two variables occur together, i.e. in this case when the BMZ's ODA disbursements in a country are accompanied by an increase in the use of modern contraceptives. However, the relationship between these two variables is not necessarily a causal one. A causal relationship only exists, for example, when the sequence of events is evident (the ODA contribution was made before the increase in use) and when other factors that might influence the cause and effect can be excluded (e.g. ODA disbursements from other donors or socio-economic trends). In the case of the secondary data analysis, neither of these factors can be excluded, which is why we speak of statistical rather than causal relationships. Statistical relationships are considered significant if the probability that they arose by chance can be ruled out. This is measured using the p-value. In the case of the secondary data analysis, a statistically significant relationship exists if the likelihood that the finding is due to chance is at most ten per cent ($p < 0.10$). The findings of the secondary data analysis show values from two analyses: the logarithmic values of BMZ ODA disbursements for SRHR, and BMZ ODA disbursements for SRHR relative to the GDP of the partner country. The first analysis allows examination of the non-linear relationships, which is why a logarithmic transformation of the monetary variables was selected. The second analysis considers the strong variation in ODA disbursements for SRHR measured in relation to the GDP of the respective recipient country, thus demonstrating that the effect of ODA disbursements for SRHR varies from partner country to partner country.

A statistically significant relationship between BMZ ODA disbursements for SRHR and the reduction in maternal mortality cannot be demonstrated, either for logarithmic

disbursements or for disbursements relative to the partner country's GDP (see Figure 16).

Figure 17 Achievement of higher-level targets for the strengthening of the right to SRH (AC 3)



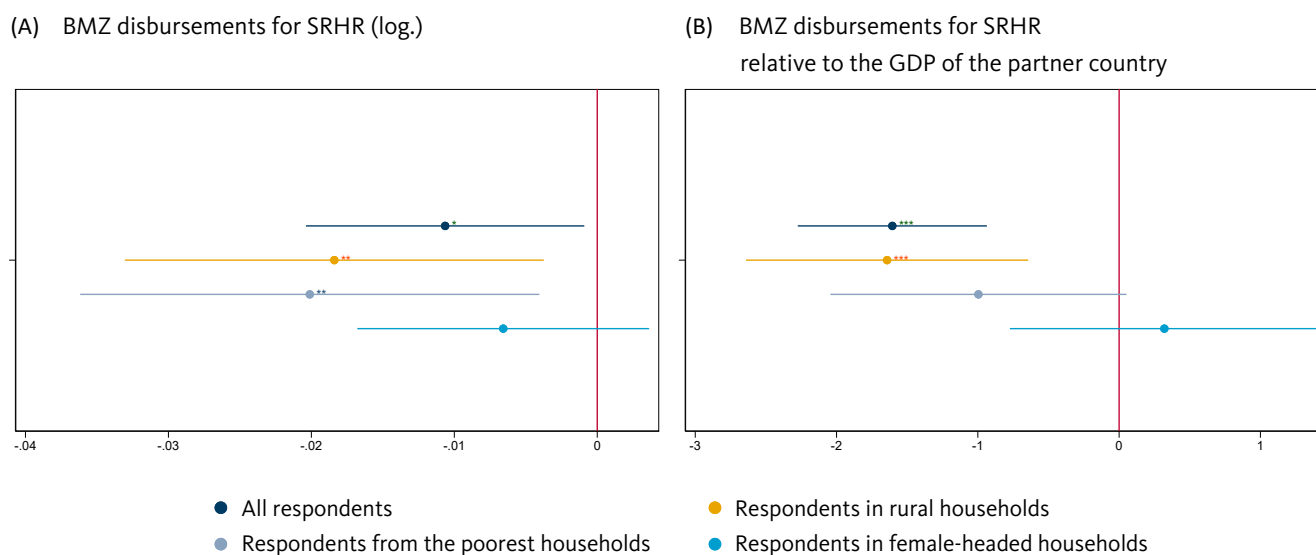
Source: DEval's own chart based on findings of the evaluation synthesis ($n_{I1}=28$, $n_{I2}=30$).

SRHR interventions contribute to reducing the number of unintended and early pregnancies among young women. According to the project evaluations, 73 per cent of the interventions (22 out of 30 reports) contribute to preventing unintended and early pregnancies among young women (indicator 3.2; see Figure 17). Interventions achieve this impact primarily by enabling a greater supply of contraceptives and better access to them (18 reports), or by increasing the acceptance and use of contraceptives (14 reports). However, the project evaluations also mention that the need is still not sufficiently met. This primarily affects youth and unmarried people. This constraint is also corroborated by the interviews in three case study countries. The continuous need for contraceptives in conjunction with difficult access for youth and people in remote rural regions has led to the number of unintended pregnancies stagnating or even increasing in some regions, especially among youth (two case study countries). The findings of the secondary

data analysis also show that an increase in early pregnancies can be observed in six out of 21 partner countries of German development cooperation for which at least two data surveys are available between 2011 and 2022. The increase varies greatly – from 0.1 per cent in Tajikistan (DHS data from 2017) to 52 per cent in Afghanistan (DHS data from 2015). However, due to the limited availability and up-to-dateness of the data, it is only possible to estimate the trend (see online annex).⁹³ The analysis of the secondary data also indicates a robust and statistically significant relationship between the SRHR activities of German development cooperation and a reduction in early pregnancies (see Figure 16). There is also a positive correlation between the contribution of German development cooperation and a reduction in early pregnancy/motherhood in rural households in the partner countries (see Figure 18). This applies to both the logarithmic ODA disbursements (A) and the ODA disbursements relative to the partner country's GDP (B).

⁹³ Child marriage is closely linked to early and unintended pregnancies, as well as to maternal mortality (see online annex).

Figure 18 Findings of the multivariate regression analysis on the relationship between BMZ disbursements for SRHR and the SRHR target indicator “early pregnancy/motherhood” for data from 2011 to 2022⁹⁴



Source: DEval's own chart, based on DHS, World Bank and UNDP data. The target indicators have been standardised for uniform presentation and better readability. The standardised values are shown on the y-axis. A deviation from the null value of the standardised values indicates a statistically significant relationship, if the confidence intervals do not cross the null value. A negative deviation points to a reduction in relation to the selected SRHR indicator, while a positive deviation points to an increase. The relationship between both the ODA disbursements and the control variables on the one hand, and the SRHR target indicators on the other, is shown with a one-year lag. The findings take into account all control variables and, depending on the data set, country and/or year fixed effects. Asterisks indicate the level of significance of the estimate (*=10 per cent, **=5 per cent, ***=1 per cent), 90 per cent confidence interval.

4.5 Efficiency

Summary of findings

Evaluation question: To what extent are bilateral interventions in the SRHR area of intervention implemented efficiently overall and to what extent are objectives achieved efficiently? (EQ 5)

Methods: Evaluation synthesis and evidence synthesis.⁹⁵

The efficiency of the interventions considered is rated overall as “partially fulfilled” (AC 1).

- The interventions receive an average efficiency score of 2.7 (indicator 1.1; partially fulfilled).
- A significant relationship exists between the year in which the interventions began and their efficiency rating. Interventions that began at a later date receive a significantly higher rating than interventions that began earlier.
- A positive correlation exists between the efficiency of interventions and the HDI of partner countries. There is a particular focus on the educational and economic dimensions of the HDI.

⁹⁴ Further information on the calculation of the statistical relationship and explanations of the chart can be found in footnote 92.

⁹⁵ The indicators and ACs are rated on the basis of the evaluation synthesis using the scale shown in Annex 8.1. Triangulation with findings of the evidence synthesis is not possible, as efficiency aspects were only analysed in very few studies.

Bilateral interventions are rated as “partially fulfilled” for specific dimensions (AC 2).

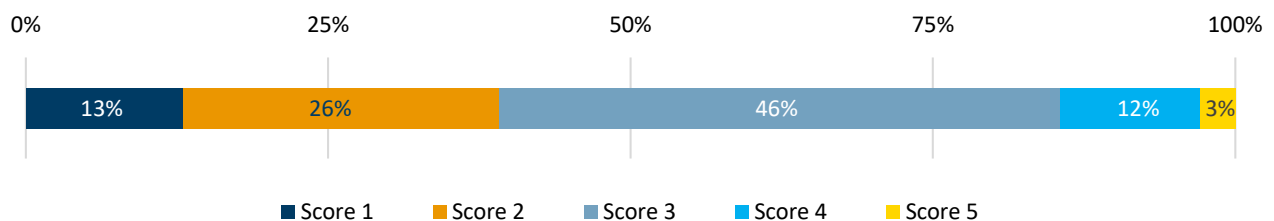
- In the evaluation reports, aspects of production efficiency are analysed more frequently than aspects of allocation efficiency.
- The majority of the interventions are rated positively in terms of their production efficiency (indicator 2.1; mostly fulfilled). Slightly more than half of the evaluated interventions are rated positively in terms of their allocation efficiency (indicator 2.2; partially fulfilled).

Overall rating of the efficiency of the interventions

The interventions analysed are **partially efficient**. The average rating in the evaluation reports analysed is 2.7 (indicator 1.1, see Figure 19): forty-six per cent (32 reports) receive a score of 3

for efficiency, around a quarter (18 reports) receive a score of 2, just over ten per cent each receive a score of 1 (nine reports) or 4 (eight reports); two interventions are awarded a score of 5.⁹⁶

Figure 19 Rating of the efficiency of the interventions overall (AC 1)



Source: DEval's own chart based on findings of the evaluation synthesis (n=69). The scores correspond to the ratings given for the evaluation criterion in the evaluation reports. To ensure comparability, the original rating categories were converted to scores from 1 to 5.

The **efficiency rating of interventions varies depending on the partner country context**. There is a positive correlation between the HDI, in particular the educational and economic dimensions of the HDI, and the efficiency rating of the interventions analysed: interventions that were implemented in partner countries with a higher HDI are rated as more efficient.⁹⁷ No other significant differences, for example in terms of approaches or regions, can be identified.

of the interventions (33 per cent) as “missed” (see Figure 20). The remainder are rated as “partially efficient”, as the evaluation reports contain indications both for and against production-efficient implementation. There are clear differences between TC and FC interventions: most evaluations of TC interventions (23 reports, 86 per cent) contain references to the fulfilment of production efficiency. By contrast, half of the reports on FC interventions contain references to an almost complete lack of production efficiency (19 reports, 50 per cent).

Rating of production and allocation efficiency

The majority of interventions fulfil production efficiency (indicator 2.1). This is rated in almost all evaluation reports (66 out of 70 reports). In slightly more than half of the interventions (56 per cent) it is rated as “fulfilled”, and in a third

Interventions that link their activities to local partners and make use of cooperation arrangements receive a higher rating for production efficiency. In the evaluation reports in which production efficiency is rated as “fulfilled” or “partially fulfilled”, it is often assumed (20 out of 66 reports) that

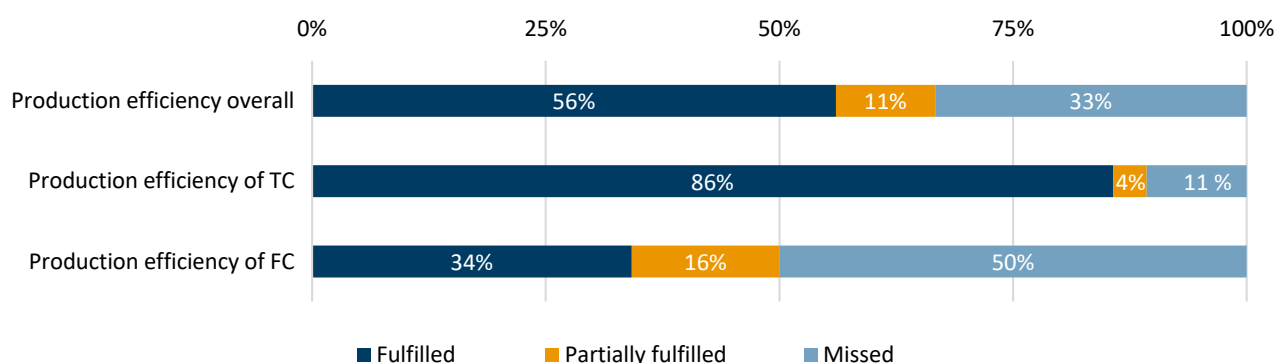
⁹⁶ A meta-evaluation by DEval to assess the efficiency of interventions in project evaluations will examine this aspect in greater depth (see <https://www.deval.org/en/evaluations/our-evaluations/meta-evaluation-of-efficiency>, accessed on 26 August 2025).

⁹⁷ Bivariate correlations were determined using Pearson's r, which can assume values between 0 and 1, with a higher value indicating a stronger correlation. Here, Pearson's r was $r=0.33$ ($p=0.003$).

a balanced cost-output ratio is plausible. This assumes that the allocation of financial and human project resources is appropriate for achieving the objectives. Furthermore, the strategic use of project resources in some interventions is in line with the intervention approach (12 reports). Some interventions use their limited budget to implement a large number of activities (seven reports). Only a few reports mention specific enabling factors for production efficiency. These include the use of synergies with other actors (such as partners), and one or two reports also mention the adaptability of project management and an effective monitoring system.

A frequently described obstacle to the production efficiency of interventions is when they do not utilise existing structures or do not cooperate with other donors on the ground. This leads to increased time expenditure and the unnecessary use of financial resources. Only a few general conclusions can be drawn on the basis of the evidence synthesis, as the impact evaluations examined also rarely provide information on production efficiency. These few studies indicate that greater use of existing resources and close cooperation with local partners and other donors can increase the efficiency of interventions (Massavon et al., 2017; Watts et al., 2015).

Figure 20 Rating of the production efficiency of the interventions (AC 2, indicator 2.1)



Source: DEval's own chart based on findings of the evaluation synthesis ($n_{total}=66, n_{TC}=28, n_{FC}=38$).

Only just over a quarter of the reports contain positive indications of allocation efficiency (indicator 2.2). Information on allocation efficiency is only contained in just over half of the reports, of which around 62 per cent contain findings that indicate efficient implementation of interventions (25 reports). Here too, the evaluation reports on TC interventions contain significantly better ratings than those of FC interventions: over 82 per cent of TC interventions receive a rating of “fulfilled” (18 reports), while 47 per cent of FC interventions are rated as “missed” (nine reports). Enabling factors are seldom mentioned, but include in particular cooperation with other donors

(11 reports) and the choice of an appropriate approach for the interventions (five reports). Two other seldom-mentioned factors are the obtaining of additional financial resources from other sources and the use of existing potential. These are consistent with the factors mentioned above for production efficiency as well as with information from case study interviews (two case study countries). Constraints are only addressed superficially in the project evaluations; insufficient use of existing potential, insufficient cooperation and harmonisation with other donors and insufficient impact monitoring are mentioned here (two case study countries).

4.6 Sustainability

Summary of findings

Evaluation question: To what extent are bilateral interventions in the SRHR area of intervention implemented overall such that their objectives are achieved sustainably? (EQ 6)

Methods: Evaluation synthesis, case studies and evidence synthesis.⁹⁸

Overall, the sustainability of bilateral interventions is rated as “partially fulfilled” (AC 1).

- The interventions receive an average sustainability rating of 2.7 (indicator 1.1; partially fulfilled).
- There is a positive correlation between the sustainability of the interventions and the educational dimension of the HDI.

For specific dimensions, the sustainability of bilateral interventions is rated as “partially fulfilled” (AC 2).

- A significant difference is found between the various combinations of approaches: the combination of infrastructure activities and capacity development within institutions, individuals and organisations is rated highest, whereas the combination of strengthening supply chains, awareness-raising activities and counselling services receives the lowest rating (indicator 2.1; partially fulfilled).
- An important success factor for sustainability is the integration of the activities into partner-country structures. In this context, an increase in capacity for the topics addressed and diversified funding are also frequently mentioned.
- The evidence synthesis shows in particular that adapting the approaches, activities and cooperation arrangements to the respective context is essential for sustainability.

Sustainability of the interventions overall

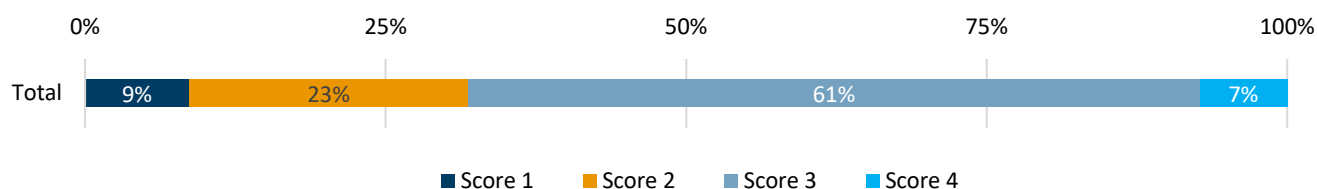
SRHR interventions only partially achieve their intended impacts sustainably. According to the project evaluations, the average sustainability score of the interventions is 2.7 (indicator 1.1). In six out of 69 reports (nine per cent), interventions receive a score of 1 and therefore make a sustainable contribution to SRHR in the partner countries. Eighty-two per cent (58 reports) of the interventions receive a score of 2 (16 reports) or 3 (42 reports). Five reports gave interventions a score of 4 (seven per cent), thus indicating that they were not sustainable. The findings of the evaluation synthesis indicate that interventions which are implemented in countries with a higher level of education are rated as more sustainable than interventions in countries with a low level of education.⁹⁹ According to the evaluation synthesis, the fragility of a country does not influence the sustainability of the interventions.

Rating of the sustainability by approaches

SRHR interventions that build infrastructure or capacities are most likely to achieve sustainability in the partner countries. The analysis of the project evaluations clearly shows that infrastructure activities perform slightly better than the other approaches in terms of sustainability (achieving an average score of 2.4 in 23 reports). Capacity development activities receive the second-best rating with an average score of 2.6 (42 reports). Interventions that include networking activities achieve the third-best rating, although this is based on only seven reports. Interventions that focus on awareness-raising activities (35 reports), support and development of supply chains (31 reports), counselling activities (15 reports) or funding activities (five reports) are rated lower on average in terms of their sustainability (on average, these scores are between 2.8 and 3). There are no differences between TC and FC interventions in terms of their sustainability ratings.

⁹⁸ The indicators and ACs are rated on the basis of the evaluation synthesis using the scale shown in Annex 8.1. Triangulation with the findings of the evidence synthesis is not possible, as sustainability aspects were only analysed in very few studies. The criterion was also considered only peripherally in the case studies, meaning that no comprehensive information is available.

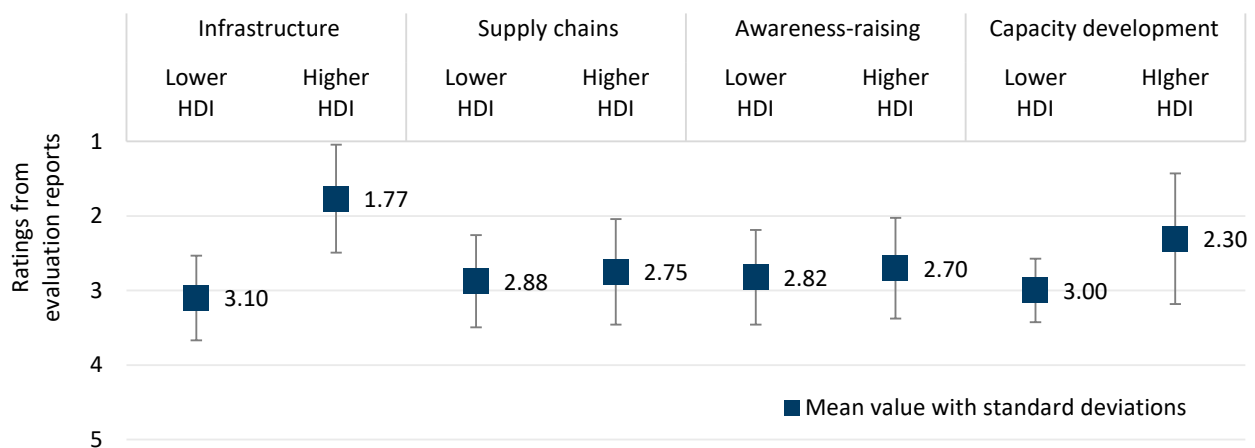
⁹⁹ Pearson's r for the educational dimension of the HDI is $r=0.32$ ($p=0.017$). The HDI also correlates with sustainability: $r=-0.37$ ($p=0.001$). There is no significant relationship between GDP, which is also part of the HDI, and sustainability ($p=0.156$).

Figure 21 Rating of the sustainability of the interventions overall (AC 1)

Source: DEval's own chart based on findings of the evaluation synthesis (n=69). The scores correspond to the ratings given to the evaluation criterion in the evaluation reports. To ensure comparability, the ratings were converted to scores on a scale of 1 to 5.

Infrastructure activities and interventions for capacity building are particularly sustainable in countries with a higher level of development. A comparison of the four most frequently used approaches in the evaluation synthesis shows that infrastructure and capacity building activities receive the highest sustainability rating in countries with a higher HDI (see Figure 22). Interventions to strengthen supply chains and raise public awareness are rated equally in countries with a higher HDI and those with a lower HDI. The evidence synthesis shows that the likelihood of achieving sustainability is higher for development activities that specifically target marginalised population groups than for activities that target the entire population. For example, the impact of funding interventions in the form of financial support during and after pregnancy may be more sustainable if the interventions target population groups of lower socio-economic status or indigenous groups (Baird et al., 2015; Celhay et al., 2017).

SRHR interventions that combine two to three approaches achieve the highest sustainability ratings on average. Interventions that use only one approach (score of 3.1) or combine more than three approaches (score of 3) receive a lower sustainability rating on average than those which combine two approaches (score of 2.4) or three (score of 2.7) (see online annex). The combination of infrastructure activities and capacity building for individuals and within institutions and organisations is awarded a score of 1.8 (11 reports), and is thus rated highest. The combination of strengthening supply chains, awareness-raising activities and counselling activities receives a score of 3 (four reports). The greater sustainability of the combination of approaches in interventions is also corroborated by the synthesis of scientific evidence. For example, funding activities such as conditional cash transfers alone only partially achieve sustainability, but in combination with capacity building or awareness-raising activities achieve greater sustainability (Baird et al., 2015; Dervisevic et al., 2021; Roy et al., 2019).

Figure 22 Rating of the sustainability by approaches and HDI of the partner countries

Source: DEval's own chart based on findings of the evaluation synthesis (n=69). The sustainability ratings were converted to scores on a scale from 1 to 5. The HDI covers the range from 0 (low HDI) to 1 (high HDI) with a threshold value of 0.50 (see also footnote 48).

Enabling and constraining factors for sustainability

The factors that influence sustainability overlap with those that influence effectiveness and impact. This applies both at the level of national and local conditions and at the level of the interventions.

Sustainability is mostly linked to the institutionalisation of the interventions within the partner countries and the long-term financial security of the activities. The analysis of the evaluation reports shows that a strong integration of the interventions into partner structures, and the partner ownership this entails, strengthen the sustainability of the interventions. The positive effect of increased partner ownership of intervention objectives, and of the agreement of strategies for the transfer of development cooperation activities to the responsibility of partner structures, was also emphasised in interviews in three case study countries. The enabling influence of ongoing, continuous funding by diversified donors is also emphasised both in the evaluation synthesis and in the case study interviews (three case study countries). Another conducive factor mentioned in the evaluation reports is enabling conditions in the political and healthcare systems (see also Section 4.3.2).

Sustainability is constrained above all by inadequate transfer to partner-country structures. Besides insufficient or no financial support, including after the interventions have been completed, the most frequently cited constraining factors are a lack of integration of the activities into the local political and healthcare systems and a lack of partner-country ownership of the interventions. These factors were also emphasised in the case study interviews. In three countries, for example, it was found that although the interventions were effective during their implementation, the activities were not continued after completion due to a lack of follow-up funding or integration into partner-country structures. A lack of strategy for transferring responsibility for the activities to the partners, high staff turnover and the absence of an explicit objective for the social, economic and environmental sustainability of the interventions were also mentioned as constraining factors in the evaluation reports – albeit less frequently. Interviewees also emphasised in particular that there is still a very high level of staff turnover in the respective healthcare sectors, which constrains the sustainability of the activities in the intervention regions (four case study countries; see also Section 4.3.2).

5.

**FINDINGS II:
SRHR IN THE YEAR 2035**

Summary of findings

Method: Scenario analysis.

Future changes in the area of SRHR will be influenced by many different factors.

- Two selected scenarios illustrate the wide range of possible future developments in the area of SRHR and underline the dynamism and uncertainty they entail.
- The scenario “From challenges to achievements” describes a future in which the global situation with regard to SRHR improves significantly.
- The scenario “Growing challenges due to normative fragmentation” envisages a world that has become increasingly polarised, resulting in disparate approaches to SRHR.

For the future strengthening of SRHR by development cooperation, there are a number of opportunities as well as challenges.

- A key challenge for strengthening SRHR lies in possible global polarisation and fragmentation along different norms. In many partner countries this development could entail the restriction of fundamental rights. Economic inequalities and global crises – such as climate change and armed conflicts – could increase the pressure on already weak healthcare systems.
- Opportunities for the future strengthening of SRHR could arise from the engagement of civil society actors in partner countries and from international alliances that are committed to SRHR. These actors and alliances can counter efforts that are directed against SRHR. Technological developments and digitalisation can also contribute to providing SRHR services for all.

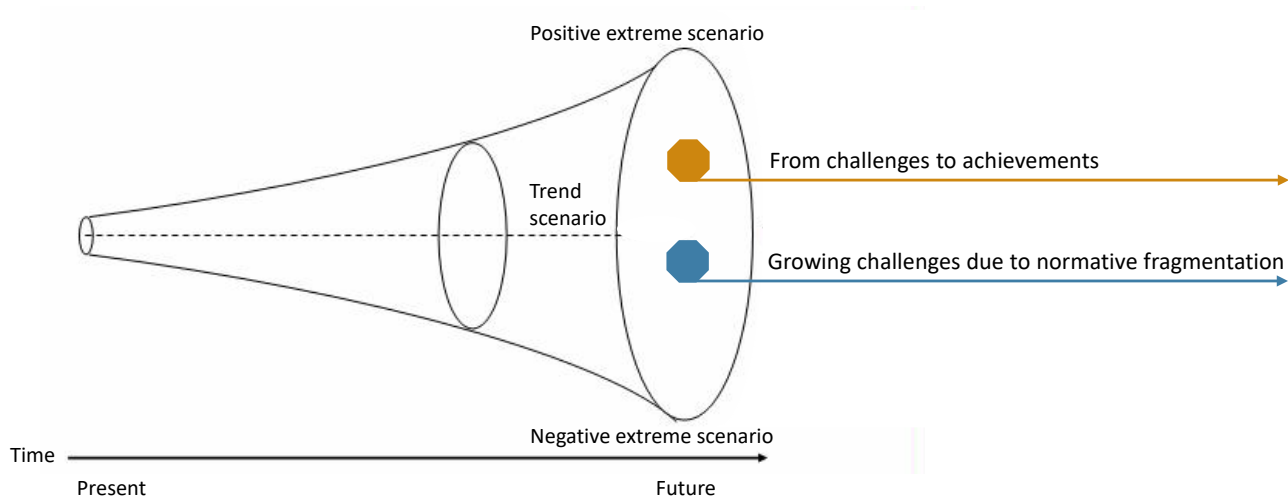
From uncertainty to a foundation for planning – scenario analysis for SRHR in the year 2035

How the area of SRHR evolves will be influenced by many different factors. As a result, numerous future scenarios are conceivable. As part of the scenario analysis, a total of 699,840 possible combinations for the future development of SRHR were identified. Of these, around 200 combinations are coherent and plausible, i.e. they are logically consistent and appear to be realistic possibilities for future developments. This high number is due to the complexity of the SRHR area with its many different influencing factors (see also Section 4.3.2). Key factors include social and political conditions, economic conditions, access to education and healthcare, conflicts and humanitarian crises, and international cooperation structures. The social dimension – social norms, values and attitudes towards gender roles, sexuality and reproductive rights – also has a strong influence. It has an effect both at the level of individuals – such as on personal attitudes towards family planning or the rights of women and minorities – and at the societal level, for example in

the form of laws, cultural traditions and social expectations (see Section 2.1 as well as Starrs et al., 2018; UNFPA, 2021a; UNICED and UNFPA, 2020). This complexity of SRHR means that the scope for possible future developments is particularly large and how the area actually evolves is correspondingly unpredictable.

The future of SRHR extends across scenarios that from the human rights-based perspective of the BMZ's area of intervention encompass both positive and negative developments in SRHR. The approximately 200 scenarios identified can be assigned to ten different clusters based on the characteristics considered, which differ primarily in terms of the projections and interactions of the key factors that are crucial for SRHR. Examples include the existence and extent of crises and humanitarian situations, the guarantee and protection of human rights, gender equality and gender norms. The clusters represent different combinations of these factors, and project both positive and negative future prospects for the targets of the SRHR area of intervention.

Figure 23 The funnel of the future and space of possibility for potential SRHR scenarios



Source: DEval, own graphic.

From the present into the future – scenarios for SRHR in the year 2035

The scenario “From challenges to achievements”¹⁰⁰ describes a future in which the global situation with regard to SRHR has been improved significantly. Gender rights and access to healthcare services have been strengthened internationally and in many partner countries of development cooperation. Attempts to restrict rights were successfully countered. This was achieved inter alia through the engagement of individual civil society movements and international alliances for SRHR, and through the use of digital technologies that improved the provision of SRHR services. Global crises have led to better prevention and response strategies, and human rights violations have been increasingly curbed. In Togo, this scenario could mean that despite resistance in rural areas, stronger networks and increased funding could lead to progress in SRHR. In Cameroon, the rights of women and sexual minorities as well as healthcare could be improved, largely driven by government support and the increased dissemination and use of digital technologies (see the scenario on page 65).

The scenario “Growing challenges due to normative fragmentation”¹⁰¹, on the other hand, illustrates possible negative developments with regard to the realisation and strengthening of SRHR for all people. In this scenario, increasing opposition to improvements in SRHR on the part of the state and (in some cases) civil society, exacerbated by crises such as pandemics and environmental disasters, has deepened the social divide with regard to SRHR. As a result, the challenges for marginalised groups have become greater and engagement for SRHR has become more difficult. For Togo, this scenario could mean that progress already made in strengthening SRHR would be jeopardised by increased social inequality and climate challenges. This could also exacerbate regional differences within the country, particularly in regions where certain aspects of SRHR are seen in a more critical light. In Cameroon, the rights of women and sexual minorities could be increasingly restricted, mainly due to widespread patriarchal norms and persistent conflicts. This constrains progress and exacerbates the already difficult situation (see the scenario on page 66).

¹⁰⁰ This scenario is far removed from the trend scenario, which extrapolates current trends, and is closer to a positive extreme scenario. This position reflects the belief of the SRHR experts that although this development is desirable, it is rather unlikely (ID 128, 129, 132, 134).

¹⁰¹ This scenario reflects the assessment of the experts surveyed. They consider a future development that closely follows the current trend to be negative, just like in the present situation (ID 127, 129, 132, 134). They see considerable challenges in the current situation in the area of SRHR which, in their view, are not only likely to persist, but could even worsen in the future.

The scenario “From challenges to achievements”

The global landscape of SRHR has changed significantly by 2035. Despite government restrictions and a backlash from state and society, individual civil society movements and international cooperation in many countries of the Global South have helped to overcome common challenges and make progress on gender equality. International solidarity and the use of digital technologies have also driven progress in gender equality. The management of crises and disasters has triggered a rethink in the prevention of and response to these events and has led to adapted activities, while human rights violations have increasingly been curbed. This also includes an increased acceptance of sexual diversity. Moreover, advancing digitalisation has further developed the medical sector and strengthened local production capacities, which has improved healthcare for women, especially in underserved regions. Nonetheless, there are still global and local differences in the implementation and availability of corresponding services.

TOGO

In 2035, the population of Togo shows a growing acceptance of SRHR overall. By strengthening the network of local partners with better networking mechanisms and increased financial resources, greater effectiveness has been achieved in the area of SRHR. Nonetheless, there is still considerable societal resistance to certain aspects of SRHR, particularly in Togo's rural areas, where these aspects are often rejected on the grounds of traditional values. Digital networking and digital medicine services are also unable to fulfil their potential as important drivers of positive change. This applies in particular to the healthcare and education sectors, as the lack of digitalisation and insufficient internet access prevent existing opportunities from being fully exploited.

CAMEROON

In 2035, Cameroon has made significant progress with regard to SRHR. This is largely due to a change of government and a new pluralistic political culture. The new course pursued by the government has led to significant progress with rights and the empowerment of women and sexual minorities. Particularly noteworthy is the integration of digital technologies into the healthcare sector, which has led to a noticeable improvement in healthcare for all. Digital medicine services enable faster and more efficient delivery of healthcare services, especially in remote rural areas. Furthermore, digital media education has had a positive impact on social attitudes towards LGBTI people. This progress is the result of closer cooperation between various Cameroonian ministries and institutions, supported by international actors. Despite this progress in the implementation of SRHR, the situation remains challenging due to persistent conflicts and climate change. The Anglophone crisis, extremist groups in the north of the country and the effects of droughts and floods are hindering efforts to comprehensively overcome social and economic problems, particularly regarding access to education and healthcare services.

Source: DEval, own presentation.

The scenario “Growing challenges due to normative fragmentation”

In 2035, the polarisation of the international community in terms of attitudes towards SRHR has further increased, leading to a growing fragmentation of international engagement in this area. This pits governments with different positions on strengthening SRHR against each other, with some in favour and others against certain aspects. Many partner countries of development cooperation are struggling with polycrises and the long-term effects of crises that began in the 2020s. Despite general economic growth in partner countries, inequalities persist. These make it difficult to empower women and give them access to basic services. International cooperation has been disrupted by controversies over gender norms, which has led to a reduction in funding and support for SRHR interventions in partner countries. This setback is reflected in the reduction of services in disaster-affected areas, the deterioration of maternal health and the increase in sexual violence and GBV, particularly in countries where patriarchal gender roles dominate. This is leading to increasing disparities in SRHR between regions within countries. Avoiding intra-societal conflicts has become a political priority for partner countries. In particular, this means focusing on addressing the inconsistent implementation of SRHR policies in different regions and the impacts of climate change on weak healthcare systems.

TOGO

Within Africa, Togo is one of the countries where SRHR is rather being supported. Women's rights are being strengthened at national policy level. Nevertheless, major inequalities still persist: although general access to education has improved in recent years, it has proved difficult to strengthen the economic situation of women in general. Progress remains unstable. There are also considerable differences between the country's regions; in the north in particular, the population is more reluctant to embrace change. Overall, the climate challenges are placing a heavy burden on the population and women in particular. This is resulting in new distribution conflicts, which also affect women disproportionately. In order to maintain social peace, interventions in the field of SRHR are often being deferred in favour of other initiatives.

CAMEROON

In 2035, rights relating to sexual orientation, gender identity and bodily autonomy remain severely restricted in Cameroon. Pregnancy terminations are still only permitted in exceptional cases, and social acceptance of these and similar rights remains low. Despite these constraints, progress has been made in recent years in combating gender inequality and violence, primarily through the work of the Ministry of Women's Empowerment and the Family. These successes can largely be attributed to pressure from the international community and individual civil society organisations, which encouraged Cameroonian governments to take action against patriarchal structures. However, since this progress was made under external pressure it remains limited, as deep-rooted patriarchal norms, especially in rural areas, are hindering the implementation of many laws and activities. The persistent conflicts are exacerbating the already difficult situation for women and sexual minorities. The Anglophone crisis and extremist groups in the northern and western regions have further strained the situation, while climate change is exacerbating economic and social challenges. Access to education and healthcare services has been further restricted, leading inter alia to an increase in unintended and early pregnancies. Despite a strong civil society and persistent opposition, there have been no changes in governance in the country for decades. The established political structures and power relations remain unchanged, which has prevented fundamental reforms and progress and resulted in the continuation of existing policies. This political stagnation is preventing changes to promote gender equality and improve the living conditions of women and marginalised groups.

Source: DEval, own presentation.

A promising future for SRHR

The scenario “From challenges to achievements” in particular demonstrates that there will be opportunities to strengthen the SRHR area over the next ten years. The scenario shows that international cooperation could lead to progress in gender equality in many countries of the Global South. The use of digital technologies and innovative approaches could improve the availability of SRHR services – especially in underserved and remote rural areas – and at the same time strengthen healthcare, education and support for marginalised groups by reducing barriers to accessing information. Furthermore, the processes of reflection on crisis prevention and response triggered by crises and disasters could be an opportunity to create more resilient and adaptable healthcare systems. The “build back better”¹⁰² approach, which has proven successful in the wake of environmental and health disasters, offers the opportunity to develop more robust infrastructure and more efficient response mechanisms that could also benefit SRHR services. Backed up by digital innovations, international cooperation could also help to reduce global inequalities and establish fairer systems for allocating SRHR resources.

Although the scenario “Growing challenges due to normative fragmentation” describes considerable risks for SRHR, opportunities can be identified here too. The growing divide between countries whose governments are committed to equality and social justice, and those whose governments uphold patriarchal norms, could provide the impetus for more intensive discussions and negotiations at international level.

This polarisation could prompt countries and international organisations working on SRHR to step up their efforts and form alliances to protect and promote SRHR. Similar to other global challenges, such as climate change, the evident urgency of the problem could lead to an increased mobilisation of resources and political interest. This could potentially increase the influence of global initiatives and lead to a renewed focus on improving SRHR. The pressure on international organisations and civil society actors could lead to more innovative approaches and strategies to ensure access to SRHR services in difficult contexts.

Despite these opportunities, developments in the scenario “Growing challenges due to normative fragmentation” suggest that the sector will face significant hurdles over the next ten years. The growing ideological divide between countries whose governments position themselves in favour of or against certain aspects of SRHR could severely hamper international cooperation and lead to uneven progress in the implementation of SRHR policies. Policies that oppose SRHR within partner countries could restrict equal access to reproductive and sexual rights and services; marginalised groups such as LGBTI people, women and poor people would be particularly affected. In many countries, basic rights could be suppressed, which would significantly impair the political and economic participation of these groups. Furthermore, a continued increase in economic inequalities and global crises – such as climate change and armed conflicts – could increase the pressure on already weak healthcare systems, making access to SRHR services in affected regions even more difficult. These crises could lead to SRHR issues being pushed into the background and remaining underfunded in the future.

¹⁰² “Build back better” is an approach that aims to use the recovery, rehabilitation and reconstruction phases after a disaster to increase the resilience of nations and communities (see also: <https://www.undrr.org/terminology/build-back-better>; accessed on 17 September 2024). This is achieved by integrating disaster risk reduction activities into the restoration of physical infrastructure and societal systems, and into the revitalisation of livelihoods, economies and the environment. The approach aims not only to restore the original state, but also to improve the structures and processes by making them more resilient to future disasters.

Even in the scenario “From challenges to achievements”, which describes progress with SRHR, problems remain. Geographical inequalities, for instance in relation to healthcare infrastructure, could persist, which would continue to limit access to basic SRHR services, particularly in rural and marginalised regions. Furthermore, the increasing dependence on technological innovations such as digital medicine could have a counterproductive effect if, for example, the infrastructure and accessibility requirements are not met. Political and legal uncertainty could also remain a problem in this scenario, as SRHR interventions continue to be influenced by changes of government and unstable political conditions. The long-term funding of such interventions is also a potential challenge, as funds are often reallocated in times of crisis, which could jeopardise SRHR interventions and weaken their impact.

6.

CONCLUSIONS AND RECOMMENDATIONS

6.1 Strengthening SRR and preparing gender-transformative change

Conclusion 1: *Bilateral development cooperation interventions often help to increase the quality, accessibility and availability of sexual and reproductive healthcare services and products. However, they make only a partial contribution towards changing values and norms that relate to sexual and reproductive rights. For example, interventions barely address the needs of rights-holders as regards bodily, sexual and reproductive autonomy, equality and bodily integrity.*

This conclusion is based on the following findings:

- **Bilateral SRHR interventions very often pursue impacts for SRH.** The focus of the interventions analysed is often on the health-related needs of rights-holders (see Section 4.1.1). Accordingly, almost all interventions pursue the higher-level objective of strengthening the SRH of girls and women (see Section 4.2). They often also achieve their direct objectives in this area. For example, they contribute to improving the quality and accessibility of SRH services or the availability of SRH products in partner countries (see Section 4.3).

- **Needs of rights-holders as regards their SRR are less often a focus.** Although some of the interventions implement activities to raise awareness and educate rights-holders, only few pursue the higher-level objective of strengthening sexual and reproductive rights (see Section 4.2). For example, very few interventions explicitly address needs for bodily, sexual and reproductive autonomy, equality and bodily integrity (see Section 4.1.1).¹⁰³ The interventions also rarely aim to change the values and norms of girls and women and people in their social environment, particularly as regards gender equality (see Section 4.3.1).

As a result, the BMZ's strategic requirements for the SRHR area of intervention are only partially implemented by bilateral development cooperation. While interventions successfully implement the SRH area of activity mentioned in the core area strategy, gaps can be identified with regard to implementation of the SRR area of activity (BMZ, 2023b).¹⁰⁴ Since this area envisages impacts that are geared towards the structural change of norms and values, the enabling conditions for transformative change, as stated in the strategy for feminist development policy as the overarching goal of development cooperation, are only partially created (BMZ, 2023a).¹⁰⁵

¹⁰³ However, the fact that these transformative effects are important is shown by the finding that existing norms and values in society or the community are cited as one of the main constraints to the effectiveness and impact of SRHR interventions (see Section 4.3.2).

¹⁰⁴ In its core area strategy, the BMZ underlines the importance of SRR as an area of activity in its own right. At the same time, the assumption is formulated that individual areas of activity within the area of intervention must cohere in order to achieve impact (see Chapter 2). For example, the increased self-determination of girls and women, as well as changes in attitude and behaviour among people in their social environment – especially boys and men, including local authorities such as religious figures – are expected to increase the demand for health services or contraceptives. This holistic understanding was established internationally at the latest with the definition of SRHR by the Guttmacher-Lancet Commission (see Section 2.1). Current scientific studies also emphasise the importance of an integrated and holistic approach to strengthening SRHR. For example, it is emphasised that multi-component interventions in particular are able to strengthen SRHR. This also includes activities that aim to change social conditions, such as prevailing values and norms in communities, for example on GBV (Starrs et al., 2018; WHO, 2007). The holistic understanding of SRHR has been part of the BMZ's SRHR strategies since at least 2008 (BMZ, 2008). Accordingly, interventions that were implemented during the period under review should also contain corresponding references.

¹⁰⁵ Besides the strengthening of SRH, the strengthening of rights, particularly in relation to sexuality and reproduction, is also a core component of feminist development policy. Strengthening rights is part of the first of four action areas defined in the strategy for feminist development policy. In this context, SRR of "girls, women and LGBTQ persons" are mentioned (BMZ, 2023a, p. 23). Other rights mentioned in the strategy – for example in relation to protection against GBV and harmful practices – are also part of SRR as defined in the area of intervention. Moreover, Germany's feminist development policy also underlines the importance of gender-transformative impacts. For example, the strategy mentions the long-term goal of dismantling gender-specific power hierarchies. To this end, development cooperation should, among other things, dismantle discriminatory laws and counteract unequal social norms and practices as well as discriminatory attitudes and gender roles and stereotypes (BMZ, 2023a). This evaluation shows that corresponding contributions to transformative change are envisaged in the area of intervention, but in practice are rarely an explicit part of the interventions.

The gap can be partly explained by the divergent interests of partners. Partner governments may reject individual aspects of SRR, making joint work on them more difficult.¹⁰⁶ This can lead to bilateral interventions not pursuing objectives relating to SRR, or only doing so implicitly (doc xxiii; doc xxiv). Alternatively, it is possible that these sensitive issues are promoted through multilateral or civil society organisations, as these entities are not always part of bilateral government negotiations. However, this evaluation has not produced any clear findings indicating that SRR in individual partner countries is strengthened through multilateral or civil society organisations in a way that complements bilateral interventions.¹⁰⁷

Dealing with strongly normative objectives is generally a challenge for bilateral development cooperation. DEval has identified similar challenges in its evaluations of the BMZ's human rights strategy and gender equality in post-conflict contexts (Brüntrup-Seidemann et al., 2021; Polak et al., 2021, 2022). The fact that human rights priorities of partner governments and BMZ priorities can be in tension with one another is also highlighted in a meta-evaluation of DEval country portfolio reviews (Vorwerk and Köder, 2024).¹⁰⁸ This challenge with regard to SRHR is also recognised in development

research. Brown (2023), for example, addresses the challenge for development cooperation of advocating for the rights of LGBTI people to partner governments, without patronising partners in a paternalistic way or provoking an ad hoc rejection as a counter-reaction. He formulates the recommendation that development cooperation should strengthen local human rights defenders and their activities on a targeted and long-term basis.

As divergent partner interests may arise even more frequently in the future, options for implementing the area of intervention should be defined in line with the partner's interest. The findings of the scenario analysis indicate that normative fragmentation and polarisation may increase both globally and within partner countries in the future (see Chapter 5). For development cooperation, this poses the challenge of strengthening SRHR also in those partner countries in which the partner governments are not interested in working together on SRR. Against this background, DEval recommends implementing SRHR in line with the interest of the partner governments and distinguishing between at least two types of partner countries: partner countries with a strong interest in taking responsibility for SRR (type 1), and partner countries with a low level of interest in doing so (type 2).

¹⁰⁶ The interest of partner governments and other state actors in working together on SRHR objectives is one of the most important factors influencing the effectiveness and impact of SRHR interventions. In interviews in individual case study countries, for example, it was pointed out that partners were particularly interested in interventions to strengthen the health system. SRR interventions, on the other hand, tended to be viewed in a critical light (see Section 4.4).

¹⁰⁷ As shown in Section 2.4, the importance of multilateral and civil society channels for the implementation of SRHR has increased significantly in recent years. However, only a very small proportion of the funds implemented through these channels is spent on specific themes and countries. Furthermore, most of these funds do not flow into countries in which bilateral development cooperation implements SRHR as an area of intervention (see online annex). Consequently, there is no evidence that politically sensitive issues are systematically implemented through other channels in those countries where the BMZ implements SRHR as part of a core area. Additionally, the findings of the case studies show that coordination between bilateral interventions and multilateral activities could be improved partially. Furthermore, this approach, in which certain sensitive topics are implemented outside of bilateral development cooperation, can also have unintended negative impacts. In particular, bypassing – in which interventions are implemented without government involvement – can reduce incentives for political and social reforms. This is discussed in the DEval evaluation of development cooperation in fragile contexts, for example (Wencker and Verspohl, 2019).

¹⁰⁸ The DEval synthesis of country portfolio reviews emphasises that partner government ownership is an important factor influencing the effectiveness and impact of development cooperation interventions. According to this, broad alignment with general development priorities alone does not automatically contribute to partner ownership of the project objectives. Moreover, DEval emphasises the heterogeneity of partners in this context: there is no single partner interest. It is rather the case that a plurality of partner interests must be assumed (Vorwerk and Köder, 2024).

Recommendation 1

For each partner country in which the SRHR area of intervention is implemented through bilateral development cooperation, the BMZ – together with the implementing organisations – should develop context-specific options for action to strengthen SRHR. Here a distinction should be drawn between at least two types of partner countries: in countries with a strong interest in also assuming responsibility for SRR alongside SRH, bilateral development cooperation should cover holistically all areas of activity within the SRHR area of intervention that relate to these partner countries. In countries with a correspondingly low level of interest, priority should first be given to creating an enabling framework for the holistic strengthening of SRHR. This will involve strengthening civil society actors and advising government partners.

Implementation guidance

- This recommendation can be applied both in countries where SRHR is already being implemented as an area of intervention and in countries where SRHR is to be commenced as a new area of intervention. The interest of partners in working together to promote SRHR can be assessed in dialogue with partner governments and on the basis of independent studies and indices¹⁰⁹ by the sector division together with the country divisions and development cooperation officers on the ground.
- Despite the fundamental interest of partner governments in working together on SRHR, the holistic strengthening of SRR may conflict with partner orientation in some areas. Implementation of the holistic approach can therefore be included in the political dialogue in order to reconcile the interests of the partner governments and the BMZ.
- The context-specific implementation of options for action can make it possible to tailor the activities to the specific needs of rights-holders within a country and to select appropriate implementation partners. Depending on the partner country context, individual modules can be implemented by state, civil society or private-sector organisations.
- In partner countries where there is little interest in working together on SRR-related issues, the BMZ can prioritise the allocation of ODA funds through multilateral or civil society channels. The do-no-harm principle must be observed here, to ensure that civil society actors in partner countries are not exposed to any risk.

The lack of focus on SRR could also be related to the high level of resources required over the long term to change norms and values. The interviews in case study countries, for example, show that a lot of time and continuous awareness-raising are required to change norms and values (see Section 4.3 and Section 4.6).¹¹⁰ More than with other development cooperation activities, constant funding is required to sensitise rights-holders to SRR, as new young adults need to be continuously targeted. Therefore, development cooperation interventions in this area can only be sustainable if they are successfully integrated into partner-country structures and can be implemented independently of development cooperation funding.

Against this background, development cooperation interventions will possibly prioritise activities that are limited in duration and that reliably promise more visible impacts. The (explicit or implicit) assumption that impacts to strengthen the healthcare system can be achieved more quickly and with fewer resources may play a role here. This can lead to an (intentional or unintentional) deprioritisation of activities designed to transform norms and values in the long term. In its synthesis of the country portfolio reviews of German bilateral development cooperation (Vorwerk and Köder, 2024), DEval shows that decisions on the design of modules are also influenced in practice by such impact expectations.

¹⁰⁹ The minimum requirement for productive cooperation could be that various marginalised groups of people are able to advocate for their (as yet unimplemented) SRR without fear of persecution. This excludes, for example, countries in which women can be imprisoned for pregnancy terminations or miscarriages, or LGBTI people can be persecuted or imprisoned because of their sexual orientation or activism.

¹¹⁰ For example, the UNFPA (2022c) also points out in a study that interventions aimed at changing attitudes and values regarding the acceptance of gender diversity and the elimination of power dynamics can also offer protection against GBV, promote health or reduce unintended pregnancies and STIs. Longer-term interventions that address participants continuously and within different formats were more effective than interventions with one-off awareness-raising activities, particularly with regard to youth.

This study emphasises that the decision in favour of certain project locations also depends on the expected greater effectiveness and impact. The needs of rights-holders may be secondary.

To counteract a possible deprioritisation of activities in the area of SRR, standard indicators should be defined for all

areas of activity in the SRHR area of intervention and used as a template when designing interventions. As a result of this process, a catalogue of qualitatively tested but non-binding indicators can be made available to those persons in the implementing organisations who are responsible for new interventions or the continuation of existing ones.¹¹¹

Recommendation 2

Together with the implementing organisations, the BMZ should define standard indicators for the intended impacts of the holistic SRHR approach. These indicators should cover all areas of activity within the SRHR area of intervention that relate directly to impacts in partner countries. In particular, indicators should also be defined for the SRR-related area of activity. These indicators should be compiled in a catalogue and used by the implementing organisations when creating results matrices.

Implementation guidance

- The pending review process for the core area 6 strategy can provide the BMZ with an opportunity to reflect on the intended direct and indirect impacts and possible target groups of the area of intervention. Based on this evaluation, a theory of change can be developed for the area of intervention and one indicator each can be formulated for the objectives of each track. The monitoring and evaluation process for the area of Private Sector Engagement can be used as an example.¹¹²
- When compiling the indicator catalogue, the BMZ and the implementing organisations can draw on various existing indicators for SRHR. This includes indicators for both the SRH area of activity and the SRR area of activity. These can be found inter alia in the indicators of the 2030 Agenda, in the DHS data or in the Multiple Indicator Cluster Survey (MICS) data. Impacts in the SRR area of activity may for instance relate to physical, psychological or sexual violence within partnerships, decision-making power over sexual and reproductive behaviour, or social and personal attitudes towards sexual and reproductive rights.¹¹³
- The catalogue of indicators can be used without obligation when creating results matrices. To ensure that the indicators are used in practice, implementing organisations can publicise the catalogue and make it available to those responsible for creating results matrices.

¹¹¹ The non-binding nature of the catalogue of indicators is intended to prevent interventions from being designed in a way that is not context-specific. This should also reduce potential risks that may be associated with standardised indicators, such as false incentives.

¹¹² In this joint process of BMZ Division 412 "Business Networks" and the GIZ sector programme Private Sector Engagement, a theory of change was developed for the entire thematic area and indicators were defined based on this (zu Eulenburg et al., 2024).

¹¹³ For further information, see for example UNFPA (2024a), Owolabi et al. (2024) and WHO (2023b).

6.2 Strengthening marginalised groups

Conclusion 2: *Formally, large marginalised groups – such as youth – are mostly addressed through activities in the SRHR area of intervention. However, the SRHR of these groups are only partially strengthened. For example, they still face barriers to accessing healthcare services. Furthermore, they are often not identified in interventions through disaggregation, and specific, smaller marginalised groups – such as LGBTI people or people with disabilities – are barely addressed at all as target groups in their own right.*

This conclusion is based on the following findings:

- **Interventions in the area of intervention mostly specify large marginalised groups, but barely address subgroups or people affected by multiple discrimination.** Most SRHR interventions are geared towards empowering women and thus formally focus on a marginalised group. Children and youth are also often specified as a target group for interventions.¹¹⁴ However, the heterogeneity of these groups is rarely considered, and individual subgroups that are more affected by structural marginalisation than others are not mentioned. Furthermore, other, smaller groups such as people with disabilities, gender-diverse people or ethnic minorities are rarely mentioned explicitly. As a result, multiple discrimination, in which several marginalising factors compound each other, is not considered (see Section 4.1).
- **Implementation of the interventions only partially succeeds in strengthening particularly marginalised groups.** Although some targeted approaches are used to reach these groups¹¹⁵, challenges remain according to

the case study findings. For example, limited financial resources in interventions without this specific focus can lead to members of marginalised groups being deprioritised. This applies, for example, to groups that have special needs for SRHR services, such as youth or women with disabilities (see Section 4.3).

Strategic requirements that the BMZ places on the area of intervention are formally taken into account in bilateral development cooperation interventions; however, there are some challenges in their implementation. Both in the BMZ's core area strategy and in strategies that go beyond this, such as the strategy for feminist development policy, the BMZ places an explicit focus on promoting marginalised groups (BMZ, 2023a, 2023b, 2023d). Although these requirements are formally implemented in bilateral interventions in this area of intervention, there are some challenges in practice.

Besides bilateral development cooperation, the BMZ can also support marginalised groups in partner countries through multilateral and international civil society organisations. The evaluation analyses the area of intervention primarily with regard to bilateral development cooperation, as contributions that flow through other channels are usually not spent on a country-specific basis (see Section 2.4).¹¹⁶ Consequently, the evaluation findings are only valid for bilateral development cooperation. The BMZ also makes financial contributions to multilateral organisations (such as UNFPA or GFF) and to international NGOs (such as IPPF), which can also support marginalised groups, among others (BMZ, 2023g). However, as these funds are usually neither earmarked nor country-specific, this evaluation does not provide any information on what

¹¹⁴ Viewing social disadvantage on the basis of group membership, which is defined according to socio-demographic variables, is highly simplistic and obscures the overall heterogeneity of these groups. Describing all women or youth in a society as equally marginalised, for example, negates the differences that may exist within these groups. Furthermore, the perspective of group-based marginalisation implies a passive role for those who are assigned to the group. This obscures the agency of members of a group. However, studies show that people who are supposedly assigned to marginalised groups, such as youth, also possess agency and can develop despite general constraints (Polak, 2012).

¹¹⁵ Examples include working with clubs/associations and with radio stations for youth, or the promotion of mobile health teams and community health workers.

¹¹⁶ Regarding multilateral organisations, this includes both earmarked contributions, which can be assigned to selected thematic areas using the CRS purpose code and tracked, for example, through the OECD DAC CRS dataset (see Section 2.4), and core contributions, which organisations can use as required, without any thematic focus (see also: <https://www.bmz.de/de/ministerium/zahlen-fakten/oda-zahlen/hintergrund/leitfaden-oda-19206>, accessed on 14 February 2025).

proportion of these funds is used to specifically strengthen the SRHR of marginalised groups.¹¹⁷

The identified challenges in strengthening the SRHR of marginalised groups have also been discussed in the specialist literature for some time. The Guttmacher-Lancet Commission points out that several groups of people are marginalised with regard to all or some aspects of SRHR (Starrs et al., 2018)¹¹⁸ and

have often not been able to benefit from the successes of SRHR to date (UNFPA, 2024a; Rose et al., 2024; Hameed, 2018; Melesse et al., 2020). The importance of systematically strengthening these marginalised groups for the area of intervention can also be illustrated by SDGs that relate to SRHR (see Box 10). Although significant progress has been made worldwide in strengthening SRHR, gaps remain in the strengthening of marginalised groups in particular (UNFPA, 2024a).

Box 10 Contributions to the 2030 Agenda for Sustainable Development

Sexual and reproductive health and rights (SRHR) are explicitly enshrined in various Sustainable Development Goals (SDGs) and are therefore an integral part of the 2030 Agenda for Sustainable Development. As part of this evaluation, primarily contributions to SDG 3 “Good health and well-being” and SDG 5 “Gender equality” were analysed. The former emphasises the right to health and the latter the right to equality and self-determination for girls and women (see also Section 2.1). Furthermore, there are strong links to the core principle of the 2030 Agenda – leave no one behind. Contributions to SDG 3 and SDG 5 are covered by the evaluation criteria of relevance, effectiveness and impact. The findings of the evaluation can be summarised as follows:

- **Substantive contributions to SDG 3 (“Good health and well-being”):** The sexual and reproductive health and rights area of intervention focuses on the targets of reducing maternal and neonatal mortality (targets 3.1 and 3.2), and universal access to sexual and reproductive healthcare services (target 3.7). According to the findings of the project evaluations, interventions mostly achieve impact for targets 3.1 and 3.7. However, the analysis of the secondary data corroborates these findings only for the contributions of German development cooperation to reducing early pregnancies (indicator 3.7.2). By contrast, no statistical correlation can be found between the German Official Development Assistance (ODA) disbursements for sexual and reproductive health and rights and the reduction in maternal mortality (see Section 4.4). At the level of direct impacts, the evaluation findings show that German development cooperation contributes to improving the quality and accessibility of sexual and reproductive healthcare services and the availability of sexual and reproductive healthcare products. However, the contribution to universal access for youth and structurally marginalised groups such as people with disabilities or lesbian, gay, bisexual, transgender and intersex people involves limitations.

¹¹⁷ As described in Section 2.4, the share of earmarked funds for SRHR that flows to multilateral organisations has increased significantly in recent years. Furthermore, there are core contributions to multilateral organisations that are not tied to a specific purpose and were therefore not taken into account in the evaluation (for an example of the importance of multilateral organisations for SRHR, see <https://www.guttmacher.org/2025/01/family-planning-impact-trump-foreign-assistance-freeze>, accessed on 14 February 2025). However, this does permit the conclusion that marginalised groups are specifically strengthened as a result of these funds. Furthermore, the increase in funding for multilateral organisations does not automatically mean that their activities complement bilateral development cooperation interventions. For example, the OECD DAC points out that to date barely any knowledge is available on the overall division of tasks between multilateral and bilateral development cooperation (OECD, 2022).

¹¹⁸ The following groups are mentioned: youth, LGBTI people, displaced people, people with disabilities, ethnic minorities and indigenous population groups, as well as people who are exposed to particular risks due to their living conditions (such as people of no fixed abode). These groups can be differentiated according to whether they are considered a marginalised group with respect to SRHR in most partner countries of development cooperation regardless of context, or whether they are marginalised in certain partner countries depending on the context. For example, it can be assumed that (certain) young people (Rose et al., 2024), economically marginalised people, people with disabilities (WHO and UNFPA, 2009), LGBTI people (Izugbara et al., 2022; Khan et al., 2024; Logie, 2023) and sex workers are marginalised in many partner countries in terms of meeting their SRHR needs. Other groups, on the other hand, are not present in every partner country, meaning that they can only be understood as a marginalised group depending on the context. Examples include displaced people, ethnic minorities and indigenous population groups.

- **Substantive contributions to SDG 5 (“Gender equality”):** The evaluation provides an insight into the consideration of the sexual and reproductive rights of girls and women through the targets on ending discrimination (target 5.1), violence (target 5.2) and harmful practices against girls and women (target 5.3). The findings reveal that the contribution of German development cooperation in the SRHR area of intervention does not fulfil the strategic requirements. For example, the interventions do not achieve corresponding direct objectives for gender equality. They are more effective in raising the awareness of girls and women and people in their social environment regarding sexual and reproductive rights. The objectives of the interventions that aim to achieve universal access to sexual and reproductive health and rights (target 5.6) are only partially achieved and are only partially aligned with the needs of rights-holders.
- **Contributions to implementing the principle of “leave no one behind”:**¹¹⁹ By signing the 2030 Agenda, all United Nations member states agreed to strengthen those people and countries that are furthest behind, have the least opportunities and are most marginalised. This aspect was analysed in the present evaluation. The evaluation concludes that although marginalised groups are formally the focus of sexual and reproductive health and rights interventions, they are often not specified. Furthermore, some marginalised groups still often face barriers to accessing sexual and reproductive health and rights services.

The lack of consideration of marginalised population groups may be linked inter alia to the lack of disaggregated data.

In its evaluation of the BMZ Action Plan for the Inclusion of Persons with Disabilities, DEval found that little disaggregated information on persons with disabilities is available during the planning of interventions, hence knowledge about context-specific marginalised groups is limited in many places. This means that an important prerequisite for the comprehensive and representative inclusion of persons with disabilities is not met (see also Hameed et al., 2020; Schwedersky et al., 2017; UNFPA, 2018). The problem of a lack of disaggregated data is also emphasised in many other scientific publications on SRHR (Nowshin et al., 2022; Starrs et al., 2018). It should be noted that, unlike in many other sectors of development cooperation, the DHS data for the health sector includes comparable and disaggregated information across countries.¹²⁰

Possible efficiency considerations may also make it more difficult to involve marginalised groups in development cooperation interventions.¹²¹ In particular, the case study findings of the present evaluation indicate that the resources available in some of the analysed interventions are not sufficient to reach all rights-holders to an equal extent. As the targeted strengthening of marginalised groups requires additional funds, the implementation of specific activities to promote marginalised groups may be deprioritised.¹²²

To counteract an unintended deprioritisation of activities for marginalised groups, the implementing organisations should manage the context-specific strengthening of these groups by disaggregating indicators to a greater extent.¹²³

In partner countries where SRHR is implemented holistically (type 1; see Section 6.1, recommendation 1), one focus should be on strengthening both large and small marginalised groups.

¹¹⁹ See <https://unsdg.un.org/2030-agenda/universal-values/leave-no-one-behind>, accessed on 2 October 2024.

¹²⁰ It must be remembered here that aggregating data can also have advantages, as it preserves the anonymity of rights-holders and avoids unintended negative effects, for example with regard to LGBTI people or patients with STIs.

¹²¹ The DEval evaluation on human rights-based approach to development policy in the “sustainable economic development” sector, for example, concludes that although disaggregated information on context-specific marginalised groups does exist, it is often not taken into account in interventions. The findings of appraisals during the planning of interventions were often described as irrelevant information for management purposes, and only a few of the interventions analysed aimed to strengthen specific marginalised groups (Polak et al., 2022).

¹²² Analysing interventions aimed at strengthening marginalised groups purely in terms of efficiency is problematic from both an ethical and a methodological perspective. Kaiser et al. (2021), for example, conclude in a scoping review that generic conclusions on the efficiency of such interventions are not possible due to the small number of studies, the heterogeneous measurement methods and the possible publication bias.

¹²³ This recommendation is to be seen in the context of a number of recommendations made by other DEval evaluations that also deal with ways of strengthening marginalised groups in interventions. For example, in its evaluation of the BMZ’s human rights-based approach, DEval recommends developing standard modular elements and accompanying measures in order to provide good practice examples for strengthening marginalised groups. Furthermore, both the DEval evaluation of the Action Plan for the Inclusion of Persons with Disabilities and the evaluation of gender equality in post-conflict contexts address the identification of marginalised groups in the planning of interventions in their recommendations (Brüntrup-Seidemann et al., 2021; Schwedersky et al., 2017). One example is the recommendation to conduct human rights-based target group analyses (Schwedersky et al., 2017).

The focus on individual marginalised groups should be context-specific, in order to ensure compliance with the do-no-harm principle (Yang and Sudarshan, 2024). There are a number of examples that can be used as a model for the disaggregation of indicators in SRHR interventions.¹²⁴ If no disaggregated data

is available in the partner countries – for instance because no DHS survey is carried out – interventions can plan to finance the necessary surveys. This is important overall, as disaggregated information can make an important contribution towards revealing social inequalities (Ponce et al., 2025).

Recommendation 3

The implementing organisations should ensure that results matrices of SRHR modules include disaggregated indicators for context-specific marginalised groups. This applies in particular to countries in which SRHR are strengthened holistically through bilateral development cooperation. When selecting indicators, the implementing organisations should incorporate the do-no-harm principle.

Implementation guidance

- The implementing organisations can identify context-specific marginalised groups based on human rights-based target group analyses. By doing so, they can also include those groups that in most partner countries of development cooperation are marginalised in terms of their SRHR. In particular, these include youth, economically and geographically marginalised people, people with disabilities, LGBTI people and sex workers.
- The availability of disaggregated data is a prerequisite for defining and monitoring disaggregated indicators. If no suitable data is available, for example from the DHS dataset, the implementing organisations can include the costs of collecting it in their plans.

Empirical evidence on effective approaches is not available to the same extent for all marginalised groups. As the DEval EGM on SRHR shows, many studies analyse interventions that inter alia aim to strengthen youth and young adults. The strengthening of people living in rural areas is also often the focus of research. By contrast, there are clear evidence gaps in relation to smaller groups, such as LGBTI people or people with disabilities (see also Hameed et al., 2020; Khan et al., 2024; Nowshin et al., 2022).

Bilateral development cooperation should therefore further develop its approaches for strengthening marginalised groups systematically and based on evidence. In the case of large marginalised groups, existing evidence-proven approaches can be used. For example, studies show that economically and spatially marginalised groups can be strengthened through outreach or community approaches (Ahmed et al., 2022; Meherali et al., 2021; Scott et al., 2015; see also Section 4.1).¹²⁵ Digital medicine approaches, such as telemedical services,

¹²⁴ Disaggregation can be performed for instance using the PROGRESS formula (Place of residence, Race/ethnicity/culture/language, Occupation, Gender/sex, Religion, Education, Socioeconomic status and Social capital), which categorises groups according to their health inequalities (O'Neill et al., 2014; WHO, 2013).

¹²⁵ These approaches attempt to bridge the distance to SRHR services by bringing them geographically closer to rights-holders and thus overcoming the so-called last mile. They usually involve local health workers who sensitise rights-holders to health-related issues close to home and at a low threshold.

can also play an important role here (see Chapter 5).¹²⁶ These approaches can also be used to specifically address the particular needs of individual marginalised groups, such as anonymity in the case of youth.¹²⁷ The few studies that have focussed on supporting these groups show that the further development

of approaches for strengthening smaller marginalised groups is also important: the likelihood of having a sustainable impact is higher for interventions with activities specifically aimed at strengthening these groups than for interventions without this focus (see Section 4.6).

Recommendation 4

The implementing organisations should continue developing approaches for the sustainable strengthening of particularly marginalised groups, and pilot these in different partner country contexts on the basis of evidence. The starting point for this should be effective approaches for strengthening particularly marginalised groups identified in the evaluation and beyond.

Implementation guidance

- The systematic selection of partner countries for the piloting of approaches makes it possible to generate comparative empirical evidence on the effectiveness and impact of the approaches in different contexts. The selection can be limited to countries in which SRHR is implemented as an area of intervention.
- For piloting, evidence on the effectiveness and impact of the approaches supplied by the monitoring and evaluation systems of the implementing organisations can be used. An alternative option is scientific monitoring of the interventions. The sustainability of impacts can also be considered, for example by systematically analysing the transfer to partner systems.
- When developing and piloting approaches, the do-no-harm principle must be observed in order to ensure that rights-holders are not placed at risk by activities, for example due to stigmatisation.

6.3 The roles of TC and FC, and their coordination

Conclusion 3: *When strengthening SRHR in partner countries, TC and FC mostly take on different roles. However, their interventions are rarely coordinated in order to achieve the higher-level objectives they share. This makes it difficult to implement the holistic approach that the BMZ requires for the SRHR area of intervention. Moreover, the allocation of roles is sometimes unclear. For example, separate TC and FC approaches are employed even though these do not match the respective BMZ profiles.*

This conclusion is based on the following findings:

- **TC and FC interventions mostly use different approaches.** To achieve joint impacts, TC and FC usually focus on complementary impact pathways: the FC portfolio is characterised by interventions that aim to strengthen supply chains and implement awareness-raising and education activities on SRR. Accordingly, the interventions often pursue the objectives of increasing the availability of SRH products or strengthening access to and the quality of awareness-raising on SRR. TC interventions, on the other hand, often focus on capacity development and activities to improve infrastructure and equipment.

¹²⁶ Besides bridging the physical distance to healthcare facilities, such activities can also provide SRHR services for those people from marginalised groups who want to maintain their anonymity due to social or political barriers to accessing healthcare facilities. Furthermore, health-based barriers such as physical limitations or infections (e.g. due to COVID-19 or Ebola) that restrict the use of conventional medical services can also be overcome (Chattu et al., 2021; Lopes et al., 2023). A prerequisite for the use of digital medicine should be that the approaches observe the principle of digital health equity (Chattu et al., 2021).

¹²⁷ The UNFPA provides a further overview of youth-friendly approaches that have been assessed as particularly effective. Its website also lists other modules that address various focal areas of SRHR and offer guidance for interventions (see <https://www.unfpa.org/youthstrategy>, accessed on 13 February 2025).

They often aim to expand SRH services, for example in healthcare facilities, and reduce corresponding barriers to access (see Section 4.2.2).

- **For some direct objectives there are overlaps between the TC and FC portfolios.** Both TC and FC interventions often have the strengthening of SRH services or of SRR counselling services as a direct objective. In these areas, the clear separation of roles that otherwise prevails does not exist. Furthermore, there are some approaches in the TC and FC portfolios that are rather atypical for the respective implementing organisations, and do not correspond to the core profiles that the BMZ requires for FC and TC (BMZ, 2021b).¹²⁸ This applies to infrastructure and equipment interventions, which are often implemented by TC in the SRHR area of intervention, and to awareness-raising and education measures, which are often implemented by FC (see Section 4.2.2).
- **Although they are often complementary in terms of content, TC and FC interventions usually do not interact.** One reason for this is the limited coordination (see Section 4.2.1). Formal coordination mechanisms do exist in the planning of interventions within German development cooperation; however, factors inherent in the system, such as different durations or different implementation regions, make it difficult for the interventions to actually cohere. Formal coordination mechanisms are usually completely absent during implementation. Here, exchange is primarily based on occasional, informal and personal communication between representatives of the respective interventions.

As a result, the potential of the mostly complementary division of roles between TC and FC cannot be utilised to strengthen SRHR through bilateral development cooperation holistically. To fulfil the BMZ's requirement in this regard and achieve impacts, different areas of activity should interact.¹²⁹ However, bilateral development cooperation interventions in partner countries are rarely implemented in a coordinated way. The fact that coordination with interventions of other development actors also succeeds in only a few cases makes the integrated and holistic strengthening of SRHR in partner countries more difficult overall.

Scientific studies indicate that the combination of several components is particularly important for strengthening SRHR in partner countries (for an overview of the evidence on the effectiveness and impact of different approaches to SRHR, see the online annex). Interventions that combine aspects of different tracks are frequently mentioned here.¹³⁰ Although several approaches are often used within the bilateral development cooperation interventions examined, this does not automatically mean that SRHR is strengthened holistically, as shown by the evaluation's findings on the division of roles between TC and FC summarised above.

The challenges identified for internal coherence are not specific to the SRHR area of intervention, but are characteristic of bilateral development cooperation as a whole. The diversity of implementation channels and modalities of German development cooperation, as well as the advantages and disadvantages associated with the complexity of its implementation structures, have long been a topic of discussion in research and development cooperation practice.¹³¹

¹²⁸ FC is often associated in particular with development cooperation modalities such as “grants, development loans, promotional loans, guarantees and equity participations”. In the case of TC, there are “besides financing, materials and equipment, training and study trips, five different instruments of human resources development alone” (see <https://blogs.idos-research.de/2017/05/18/die-instrumente-der-deutschen-entwicklungszusammenarbeit-zukunftsfaeihige-vielfalt-oder-weiterhin-reformbeduerftige-ueberdiversifizierung/>, accessed on 13 August 2024).

¹²⁹ For example, changes in the attitudes of girls and women as well as of people in their social environment should increase the demand for SRHR services and products. By simultaneously increasing the quality and accessibility of these services and products, the overall health of mothers and newborns should be improved. A prerequisite for the possible interaction of these areas is that the respective activities are linked in terms of place and timing (see Sections 2.2 and 2.3).

¹³⁰ For example, studies show that combining the social marketing approach with training activities for healthcare personnel can contribute to an improvement in attitudes towards modern contraceptives and the utilisation of healthcare services (Hinson et al., 2020). A combination of several approaches is also important for strengthening marginalised groups or promoting SRHR in conflict contexts. For example, studies indicate that youth are reached through comprehensive sexuality education (CSE) especially when school-based activities are combined with community-based elements or youth-friendly healthcare services (including the distribution of condoms by providers trained in respectful, non-judgemental and needs-based interactions with youth) (see also: <https://www.unfpa.org/youthstrategy>, accessed on 23 April 2025).

¹³¹ See for example <https://blogs.idos-research.de/2017/05/18/die-instrumente-der-deutschen-entwicklungszusammenarbeit-zukunftsfaeihige-vielfalt-oder-weiterhin-reformbeduerftige-ueberdiversifizierung/>, accessed on 15 August 2024.

Challenges to the internal coherence of bilateral development cooperation are also identified in a number of studies and evaluations. For example, coordination between TC and FC in other areas of intervention is usually only based on informal exchange, and collaboration often only takes place in the course of work on joint reporting. By contrast, the joint planning and implementation of modules only takes place in isolated cases (doc xxii). DEval evaluations formulate similar findings across sectors. For example, DEval's synthesis of country portfolio reviews emphasises that the “dovetailing of TC and FC [...] does not succeed systematically” (Vorwerk and Köder, 2024, p. 30). While communication between interventions often works well, potential synergies are often not systematically identified and utilised. For example, TC and FC are barely dovetailed at an operational level. Collaboration is made more difficult *inter alia* by the different time horizons of the modules and delays in the implementation of individual modules (see Amine et al., 2021). The geographical heterogeneity of modules can also make dovetailing more difficult, for example when activities are implemented in different regions.

To implement the SRHR area of intervention holistically in partner countries, the BMZ should make comprehensive use of development cooperation programmes. In the management structure of bilateral development cooperation, development cooperation programmes are an instrument with which modules within an area of intervention can be combined at country level.¹³² These development cooperation programmes are intended to address many of the challenges of internal coherence identified in this evaluation. In partner countries where SRHR is implemented holistically (type 1; see Section 6.1, recommendation 1), development cooperation programmes should therefore be used to combine TC and FC modules that

complement each other in terms of content such that their location and timing can be coordinated.¹³³

When implementing development cooperation programmes in the area of intervention, the known challenges for their implementation should be taken into account. Although the area of intervention is implemented through several bilateral development cooperation modules in all six case study countries examined, development cooperation programmes only exist in three countries. Where development cooperation programmes do exist, some of them have not been updated, which means that the current modules no longer correspond to the original development cooperation programmes. The findings of other DEval evaluations point to general challenges in the implementation of development cooperation programmes. For example, an evaluation of the impact orientation of development cooperation programmes concludes that the “interaction between modules [...] is currently not being written down sufficiently and transparently” in these programmes (Amine et al., 2021, p. viii). As a result, in practice modules rarely cohere operationally. The DEval synthesis of country portfolio reviews also emphasises that new development cooperation programmes often only form a loose framework for existing modules, without these modules being aligned. This can lead to a lack of clarity regarding the objectives of development cooperation programmes. Joint planning processes when designing development cooperation programmes can help to strengthen the coherence of modules (Vorwerk and Köder, 2024). Consequently, in its evaluation of the impact orientation of development cooperation programmes, DEval calls for their objective indicators to be improved so that long-term contributions can be mapped, or so that modules which do not contribute to development cooperation programmes can be excluded from them (Amine et al., 2021).

¹³² Development cooperation programmes are the BMZ's main instrument for ensuring the internal coherence of bilateral development cooperation. The interventions referred to as modules, which together contribute to impacts in an area of intervention, are combined in development cooperation programmes. These programmes define the shared, higher-level objectives of bilateral development cooperation and describe the interaction of the associated modules. Development cooperation programmes generate impact exclusively through the modules they combine (doc.xviii).

¹³³ This recommendation is to be seen in the context of other DEval evaluations. For example, the DEval synthesis of country portfolio reviews suggests that the BMZ should strengthen the binding nature of management instruments such as development cooperation programmes (Vorwerk and Köder, 2024). When implementing development cooperation programmes in the SRHR area of intervention, for example, it should be ensured that modules which aim to change the attitudes of rights-holders are carried out in the same places and at the same time as interventions that strengthen healthcare facilities. In this way, the supply of SRH services and the demand for them can be increased simultaneously.

Recommendation 5

In all partner countries where SRHR is implemented holistically, the BMZ and the implementing organisations should ensure that bilateral development cooperation modules for SRHR are coordinated and make a joint contribution towards long-term, higher-level objectives. To this end, they should in each case implement a development cooperation programme that encompasses all modules for the area of intervention. The programmes should define how the individual SRHR modules are coordinated such that their activities and impacts form a coherent whole in terms of content, place and time.

Implementation guidance

- When designing development cooperation programmes, the BMZ and the implementing organisations can focus on ensuring that complementary interventions cohere in terms of timing and place and contribute to higher-level, long-term objectives for strengthening SRHR.
- The BMZ and the implementing organisations can take into account known challenges in the implementation of development cooperation programmes. This includes the definition of interfaces between modules, the consideration of different time horizons in the implementation of TC and FC modules, the definition and operationalisation of clear higher-level objectives using measurable indicators, and the establishment of formal mechanisms for coordination during the implementation of development cooperation modules and programmes.

6.4 Context-specific use of sustainable, effective and impactful approaches

Conclusion 4: Some bilateral development cooperation approaches are more resistant to challenging contextual conditions in partner countries than others. In particular, the average effectiveness and impact of infrastructure interventions and capacity development interventions is lower in countries with a lower HDI and in fragile contexts than it is in other country contexts. By contrast, the effectiveness and impact of other approaches barely varies at all between country contexts.

This conclusion is based on the following findings:

- **The rating of the relevance and sustainability of SRHR interventions in particular differs depending on the approach used.** In the evaluation reports examined for interventions that include activities to improve infrastructure or capacity development activities, these two criteria are rated better on average than the average for other SRHR interventions. Furthermore, interventions with infrastructure activities receive a better rating for their impact than the average for all other interventions. This is also reflected in a better average overall rating

of the interventions. By contrast, interventions that aim to strengthen supply chains or raise awareness of SRHR receive lower overall scores than the average for all other interventions.

- **The success of individual approaches is highly context-dependent.** For example, interventions that focus inter alia on strengthening infrastructure and equipment receive lower average scores for their effectiveness, impact and sustainability in countries with a lower HDI and in fragile states than in other contexts. Similarly, interventions that implement capacity development activities are also less effective on average in these contexts. In both cases, sustainability in particular is lower.¹³⁴ By contrast, the rating of other approaches is context-independent: the effectiveness, impact and sustainability of interventions that inter alia strengthen supply chains and carry out awareness-raising activities are similar in countries with higher and lower HDIs. The same applies to the fragility of partner countries.

¹³⁴ This finding of the limited effectiveness and impact of certain approaches in fragile contexts supplements DEval's findings, which indicate that there are no cross-sectoral differences in the effectiveness and impact of bilateral development cooperation interventions with regard to the type of fragility of a partner country (Wencker and Verspohl, 2019).

The current focus of Germany's bilateral development cooperation portfolio on sub-Saharan African countries points to challenges for the implementation of the SRHR area of intervention. The strategy for core area 6 emphasises that bilateral development cooperation should focus on low income countries "primarily in African and Asia" (BMZ, 2023b, p. 15). This is reflected in the SRHR portfolio of bilateral development cooperation. The majority of ODA for SRHR flows to countries in sub-Saharan Africa (see Section 2.4). Furthermore, all partner countries in which activities in the SRHR area of intervention were being implemented at the time data was collected are located in this region. Most of these are least developed countries (LDCs).¹³⁵ This therefore raises the question of how German development cooperation interventions can be designed effectively, impactfully and sustainably in less conducive contexts.¹³⁶

This finding is also worth considering in light of the potential increase in challenges for SRHR identified in the scenario analysis. The "Growing challenges due to normative fragmentation" scenario describes a future in which normative polarisation increases both internationally and within societies. This is exacerbated by increasing crises and disasters, so that this scenario assumes an overall increase in fragility within societies (see Chapter 5). These challenges already exist in some cases, as the findings of the case study countries show. For example, interviewees in fragile case study countries mention the limited sustainability of infrastructure interventions resulting from difficulties in maintenance (see Section 4.6).

Overall, there is a broad evidence base on the effectiveness and impact of individual approaches in the field of SRHR. The DEval EGM refers to the large number of high-quality studies on the effectiveness and impact of approaches designed to strengthen SRHR. This broad evidence base is also reflected in studies on particularly effective and impactful approaches, otherwise known as High Impact Practices (HIPs).¹³⁷ There is good scientific evidence for some approaches that are implemented by bilateral development cooperation interventions. This applies in particular to approaches that focus on building capacity in healthcare facilities (by strengthening leadership and management skills and training healthcare personnel), or increasing awareness-raising and education (inter alia by strengthening mobile or community-based services, by pursuing social marketing or by involving men). There are no clear scientific findings on other frequently used approaches such as policy advice, activities to improve infrastructure or equipment, or the strengthening of supply chains.¹³⁸ Other approaches are also cited in the scientific debate, but these are rarely used in bilateral development cooperation. For example, only few activities are implemented that are geared towards public health financing or direct financing payments to rights-holders (see Section 4.2.2 and the online annex).

As the DEval EGM on SRHR shows, the scientific evidence on the effectiveness and impact of approaches is patchy in various contexts – and particularly so in challenging ones (Khan et al., 2024). However, there are isolated studies that

¹³⁵ A total of 33 of the 46 LDCs are located in sub-Saharan Africa (see <https://www.oecd.org/content/dam/oecd/en/topics/policy-sub-issues/oda-eligibility-and-conditions/DAC-List-of-ODA-Recipients-for-reporting-2024-25-flows.pdf>, accessed on 12 August 2024).

¹³⁶ In sub-Saharan Africa, the maternal mortality rate is significantly higher than in other regions despite significant declines (-33 per cent in the period 2000-2020). While the countries of sub-Saharan Africa had an average maternal mortality rate of 545 women per 100,000 live births in 2020, the average in North Africa and West Asia, for example, was 84 women per 100,000 live births and in Central and South Asia 129 (UNFPA, 2020). Women's ability to make autonomous decisions concerning their own sexuality and reproduction is also lower on average in sub-Saharan Africa than in most other regions of the world. Here, the proportion of girls and women between the ages of 15 and 49 who are able to make autonomous decisions on their own sexuality and reproduction is 48 per cent on average (according to the most recent data available for the period 2007-2018). Only in Central and South Asia are the average figures lower at 43 per cent (UNFPA, 2020). The current challenges for SRHR are therefore particularly significant in countries with lower prosperity. Overall, studies point out that poverty, lack of educational opportunities and conflict significantly increase the challenges for SRHR (Starrs et al., 2018; UNFPA, 2021b).

¹³⁷ A total of 23 HIPs in three areas and four enhancement HIPs are presented. Besides approaches to build enabling frameworks for SRHR (for example by strengthening public health finance or education for girls), HIPs are listed in the areas of "SRHR service delivery" (for example through outreach or community approaches) and "social and behavioural change" (for example through cooperation with mass media) (see <https://www.fphighimpactpractices.org/briefs/family-planning-high-impact-practices-list/>, accessed on 5 March 2025).

¹³⁸ Here, discrepancies can be identified between the DEval EGM and the HIPs. For example, "Strategic social accountability" and "Supply chain logistics" are specified as HIPs, although according to the DEval EGM there is a gap in the evidence for these. There were also only a few studies on legal frameworks and policy advice, although this area is mentioned prominently in the HIPs (Khan et al., 2024).

can provide indications of effective and impactful approaches in these contexts. For example, in their analysis of 29 studies, Singh et al. (2018) conclude that SRH in humanitarian crises can be improved through activities such as home visits and peer-to-peer counselling services or by strengthening health workers or community-based health workers.¹³⁹

Due to this gap, a systematic and evidence-based analysis of the context-specific effectiveness, impact and sustainability of specific approaches should take place. The findings of the present evaluation and of scientific studies can be used as a starting point for this. On this basis, the use of specific approaches to strengthen SRHR can be guided by evidence, even in fragile or challenging contexts.¹⁴⁰

Recommendation 6

The BMZ and the implementing organisations should continue developing the evidence-based use of approaches for SRHR by making structured use of existing databases containing evidence on the effectiveness and impact of these approaches. This includes both internal evidence from monitoring and evaluation as well as external evidence from scientific studies.

Implementation guidance

- The BMZ and the implementing organisations can align the evidence-based management of the area of intervention with the vision of a comprehensive evidence agenda in the long term. This can provide for external and internal empirical information to be systematically stored, assigned to the portfolio and used as a basis for creating the theory of change for individual development cooperation programmes and modules. Examples include the monitoring and evaluation system for the thematic area Private Sector Engagement, which is currently being developed, and the Interactive Outcome and Evidence Framework of the International Rescue Committee (IRC).¹⁴¹
- The BMZ and the implementing organisations can continue the SRHR EGM created in the course of this evaluation and turn it into a living EGM by continuously adding new studies to it. The content of the studies contained in the EGM can be analysed, for example through systematic reviews on individual topics. In order to close evidence gaps, rigorous impact evaluations of interventions can also be carried out in a targeted manner.¹⁴²

¹³⁹ In its thematic focus report on development cooperation in fragile states, DEval shows that there are clear limits to transitional development cooperation in contexts of particularly high fragility. The report clearly shows that development cooperation can have a structure-building effect in less fragile contexts if there are capable partners who take ownership of the development cooperation themes (Faust et al., 2023).

¹⁴⁰ This recommendation is to be seen in the context of the findings of a DEval study on the use of so-called rigorous impact evaluations, in which a series of steps were formulated to strengthen the use of evidence in German development cooperation practice. This includes inter alia the systematic synthesis of scientific studies on the effectiveness and impact of interventions (Krämer et al., 2021). Similarly, the DEval synthesis of country portfolio reviews recommends the more rigorous pursuit of an evidence agenda in BMZ country divisions (Vorwerk and Köder, 2024).

¹⁴¹ See https://oef.rescue.org/#/home?_k=t1m3vc, accessed on 10 October 2024.

¹⁴² DEval is currently supporting nine rigorous impact evaluations as part of its funding programme. To find out more, see <https://rie.deval.org/de/rie-foerderprogramm/das-rie-foerderprogramm/foerderprogramm>, accessed on 10 March 2025.

6.5 Strategic foresight in the area of intervention

Conclusion 5: *Due to a variety of interactions with other sectors, the future environment for strengthening SRHR in partner countries is uncertain. In particular, a normative polarisation of attitudes towards SRHR and an increase in conflicts and climate change-induced disasters may pose challenges for strengthening SRHR in the future. Opportunities for the future development of SRHR will arise from the digitalisation of healthcare and from strong civil society actors who are committed to SRHR.*

This conclusion is based on the following findings:

- **The future environment for SRHR remains complex due to the many different interactions with other factors and sectors.** The two selected future scenarios for the development of SRHR up to 2035 illustrate the range of future opportunities and challenges. The scenario “From challenges to achievements” describes a future in which the global situation with regard to SRHR improves significantly. The “Growing challenges due to normative fragmentation” scenario, on the other hand, describes a future characterised by normative polarisation of attitudes to SRHR.
- **These changes will affect the situation in the partner countries.** The national projections of the “From challenges to achievements” scenario for Togo and Cameroon identify potential: digital technologies, the engagement of civil society actors and partnerships in international cooperation can make important contributions to strengthening SRHR in the future. However, limitations must be taken into account, particularly in remote rural regions where access to technologies and resources

is limited. The national observations in the “Growing challenges due to normative fragmentation” scenario illustrate developments that can be traced back to anti-SRHR norms, regional differences, conflicts or climate change.

The scenarios identify potential for a positive transformation.

Both scenarios are characterised by the increasing importance of technology and digitalisation for SRHR. This transformative potential is also emphasised in other studies. For example, the UNFPA points out that digitalisation can improve access to SRH services – especially in remote rural regions – through new healthcare models such as self-care and remote diagnostics (UNFPA, 2024b, 2024c). Furthermore, the role of individual civil society actors is emphasised in both scenarios. These actors can be key drivers for advancing SRHR even if there are opposing efforts at international and national level. This potential can also be illustrated using a current example: in 2024, civil society organisations in the Gambia successfully prevented the law punishing FGM from being revoked.¹⁴³ Civil society and international actors can support each other in such endeavours.

The scenarios also draw attention to future challenges for SRHR.

Both scenarios clearly show that normative polarisation at international and national level, combined with social and economic inequality, can lead to increasing conflicts within societies.¹⁴⁴ This can make it more difficult to strengthen SRHR in many partner countries. Increasing armed conflicts at national or regional level and the effects of climate change may also contribute to this. An analysis by the UNFPA (2023) corroborates this finding – and also identified conflicts and the impacts of climate change as fundamental future challenges for SRHR.

¹⁴³ After some political and religious authorities attempted to repeal the 2015 Women's (Amendment) Act, which criminalises FGM, civil society organisations mobilised in order to defend the law through public demonstrations, legal advocacy work and awareness-raising campaigns on the harmful effects of FGM. Activists publicised survivor testimonies that played a crucial role in highlighting the severe physical and psychological consequences of FGM. As a result, the Gambian parliament eventually rejected the bill to repeal the Women's (Amendment) Act. The Gambia is not the only country where the importance of a strong civil society for strengthening SRHR is becoming clear. Recent examples from Mexico and Argentina also show this. In Mexico, civil society groups succeeded in having pregnancy terminations legalised in 2021 after years of campaigning. Similarly, the previous year in Argentina, the “Green Wave” movement led to the legalisation of pregnancy terminations. At the same time, however, it must be recognised that civil society is always pluralistic and heterogeneous. The buzzword “bad civil society” refers to the fact that civil society – as a value-neutral, analytical construct – can also include actors and movements that work against human rights (Chambers and Kopstein, 2001).

¹⁴⁴ Donald Trump's first term in office (2017-2021) showed how political polarisation can negatively affect SRHR. Specific examples were the reintroduction and extension of the Global Gag Rule (which stipulates that non-governmental organisations that provide information on and services for pregnancy terminations, or support them politically, will have their government funding cut) and the reduction in funding for the UNFPA. Trump's current second term in office (since January 2025) is continuing this trend. The announced closure of USAID, the world's largest bilateral donor organisation for development cooperation, is particularly serious. This is likely to have far-reaching consequences for SRHR programmes worldwide, particularly in Africa, where USAID plays a central role in promoting health.

Based on the scenario analysis, the BMZ should address and counteract these challenges. As the future context can also change rapidly, the BMZ should regularly conduct strategic foresight processes and incorporate them into the management of the area of intervention. This can build on experience with processes that have already been implemented (BMZ, 2018b).¹⁴⁵ This kind of strategic foresight process is important for development cooperation as a whole. These processes are particularly important for SRHR, however,

as this is an area that is characterised by a high degree of complexity and dynamism and is influenced by many social, political and technological factors. Moreover, SRHR – like other areas – is particularly susceptible to unforeseen events such as pandemics or political upheavals. Strategic foresight processes can not only help to systematically capture this complexity; they also make it possible to anticipate future developments and manage strategies and plans accordingly.

Recommendation 7

The BMZ should further refine the strategic foresight processes implemented in the past, such as those expressed in the “Development Policy 2032” study, and regularly continue them at cross-sectoral level. This will enable the systematic analysis of future opportunities and challenges for development policy, and the preparation of responses to them. In the future, the outcomes of this process and the findings of the scenario analysis should be used for strategic management of the SRHR area of intervention.

Implementation guidance

- The BMZ can organise strategic foresight processes cost-efficiently by combining them across sectors. This can prevent the fragmentation of similar processes.
- The findings of this scenario analysis can provide the BMZ with a starting point for strategic management of the area of intervention. Using this as a basis, the BMZ can analyse the opportunities and challenges in the first year. In subsequent years, the findings can then be updated based on findings across sectors.
- To determine the effects on various areas of intervention and partner countries on a context-specific basis, the BMZ can incorporate perspectives and positions from implementing organisations and partner countries into the strategic foresight process.
- When formulating responses to possible future challenges, the sector division can consider a re-prioritisation of activities and a reallocation of ODA funds. Furthermore, needed processes of consultation with partners can also be discussed in advance in order to facilitate prompt response to any challenges that arise at short notice.

¹⁴⁵ This document states that managing the future strategically is an important aspect of the BMZ's institutional control: “From this, we have learned that strategic foresight is a critical component of policy and strategy development” (BMZ, 2018b, p. 2). For further information, see <https://www.bmz.de/de/ministerium/arbeitsweise/strategische-vorausschau-52858>, accessed on 9 October 2024. The importance of foresight as a policy management tool is also clear from the German government's coalition agreement, which was in force at the time of the evaluation. The agreement states that the “instrument of strategic foresight [...] will be effectively institutionalised” (German Federal Government, 2025, p. 57). As a key task of a national security council, this instrument is of major overall importance for internationally oriented policy areas.

7.

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8.

ANNEX

8.1 Rating scale for DEval evaluations

For questions that are assessed (EQs 1.1, 1.2, 2.1, 3.1-3.3, 4.1, 5 and 6), an aspiration level is defined a priori. For this purpose, the DEval rating scale is used to produce a summary assessment at the level of the EQs.

Table 2 Rating scale and aspiration level¹⁴⁶

Categories	Definition	Aspiration level
Fulfilled	The measure fulfils the aspiration level with regard to the specified evaluation criterion. The findings confirm the fulfilment of the aspiration level.	On average, 80 to 100 per cent of the interventions examined implement one indicator. ¹⁴⁷
Mostly fulfilled	The measure mostly fulfils the aspiration level with regard to the specified evaluation criterion. Findings confirming the fulfilment of the aspiration level predominate.	On average, 60 to 79 per cent of the interventions examined implement one indicator.
Partially fulfilled	The measure partially fulfils the aspiration level with regard to the specified evaluation criterion. Findings confirming and findings confuting fulfilment of the aspiration level are in counterbalance.	On average, 40 to 59 per cent of the interventions examined implement one indicator.
Barely fulfilled	The measure barely fulfils the aspiration level with regard to the specified evaluation criterion. Findings confuting the fulfilment of the aspiration level predominate.	On average, 20 to 39 per cent of the interventions examined implement one indicator.
Missed	The measure misses the aspiration level with regard to the specified evaluation criterion. The findings confirm that the aspiration level has been missed.	On average, 0 to 19 per cent of the interventions examined implement one indicator.

¹⁴⁶ Besides these five categories, the DEval rating scale also includes a sixth category – “exceeded”. Since the ACs used in this evaluation already represent a maximum with regard to the requirements of the area of intervention, it makes no sense to use a category “exceeded”. This category is therefore not applied in this evaluation.

¹⁴⁷ The findings of the evaluation synthesis per indicator were used as the basis for calculating the rating, as these are available in a standardised form for all indicators and are based on an examination of all evaluated interventions in the period under review. Additionally, findings from the case studies were used as a correction for the rating: if the rating of an indicator in the case studies was significantly better or worse than the rating of the evaluation synthesis (2 categories above the rating based on the evaluation synthesis), the rating was corrected to the next higher or next lower category.

8.2 Evaluation matrix

The evaluation matrix contains the ACs and indicators for those EQs for which an assessment is made. The assessment follows the above rating scale, which can be based on different methods depending on the evaluation criteria.¹⁴⁸

Relevance

EQ 1: To what extent are bilateral interventions in the SRHR area of intervention relevant overall?		
Assessment criteria	Indicators	Methods
EQ 1.1: To what extent are the activities and objectives of bilateral interventions in the SRHR area of intervention aligned with the SRHR needs of directly addressed rights-holders and structurally marginalised groups?		
AC 1: Alignment of interventions with SRH needs of rights-holders	I 1.1: Alignment of interventions with SRH needs of rights-holders	<ul style="list-style-type: none"> • Evaluation synthesis • Case studies: vulnerability analysis of structurally marginalised groups in the region of intervention and in the partner country • In-person and remote case studies: interviews or focus group discussions, for instance with implementing organisation staff responsible for projects, representatives of projects (TC)/ project executing agencies (FC), government and civil society partners, direct target groups
	I 1.2: Alignment of interventions with needs of rights-holders regarding modern contraceptives	
AC 2: Alignment of interventions with SRR needs of rights-holders	I 2.1: Alignment of interventions with needs of rights-holders regarding information on sexuality and reproduction	
	I 2.2: Alignment of interventions with needs of rights-holders regarding the right to equality	
	I 2.3: Alignment of interventions with needs of rights-holders regarding the right to bodily integrity	
	I 2.4: Alignment of interventions with needs of rights-holders regarding the right to bodily, sexual and reproductive autonomy	
	I 2.5: Alignment of interventions with needs of rights-holders regarding the right to legal personality	
EF 1.2: To what extent are the activities and objectives of bilateral interventions in the SRHR area of intervention aligned with the policies and priorities of development partners and the BMZ?		
AC 1: Alignment of intervention objectives with policies and priorities of German development cooperation	I 1.1: Consistency of intervention objectives with policies and priorities of German development cooperation	<ul style="list-style-type: none"> • Evaluation synthesis
AC 2: Alignment of intervention objectives with policies and priorities of partners	I 2.1: Consistency of intervention objectives with policies and priorities of partners	

¹⁴⁸ Compared to the original evaluation matrix, which was developed for the inception report of the evaluation, minor adjustments have been made, in particular due to limitations of individual methods. These only became apparent during data collection and analysis, and therefore could not be taken into account beforehand. Specifically, the following adjustments were made: (1) removal of the original AC 1 from EQ 1.1 and restructuring of the remaining indicators into two ACs; (2) removal of the original AC 1 from EQ 2.1; (3) removal of the original AC 3 from EQ 5 and (4) removal of the original AC 3 from EQ 6; (5) rewording of indicator I1.2 in EQ 3.2 so that – in line with the wording in the report – the term “product for SRH” is used instead of “SRH product”. Furthermore, (6) an EQ on the influencing factors for impact was removed, as the influencing factors at this level were congruent with influencing factors at outcome level. During the final editing process, (7) the wording of individual ACs and indicators was also adjusted.

Coherence

EF 2: To what extent do bilateral interventions in the SRHR area of intervention cohere in partner countries overall?

Assessment criteria	Indicators	Methods
EF 2.1: To what extent do bilateral interventions in the SRHR area of intervention cohere with each other and with the activities of other bilateral and multilateral donors?		
AC 1: Synergies of bilateral interventions with interventions of other development partners during design and implementation	I 1.1: Knowledge of bilateral project managers on other key SRHR actors in the partner country	<ul style="list-style-type: none"> In-person and remote case studies: context and stakeholder analysis with information on other important implementing actors in the partner country In-person and remote case studies: interviews or focus group discussions, for instance with implementing organisation staff responsible for projects, representatives of projects (TC)/project executing agencies (FC), government and civil society partners, direct target groups, other development partners
	I 1.2: Use of mechanisms for coordination with other development partners during the planning phase of interventions (theoretical harmonisation)	
	I 1.3: Use of mechanisms for coordination with other development partners during the implementation phase of interventions (practical harmonisation)	
AC 2: Synergies of bilateral interventions with other interventions financed or cofinanced by the BMZ during design and implementation	I 2.1: Knowledge of bilateral project managers on the entire portfolio of SRHR activities financed or cofinanced by the BMZ in the partner country	
	I 2.2: Use of mechanisms for coordination of interventions with activities financed or cofinanced by the BMZ during the planning phase (theoretical harmonisation)	
	I 2.3: Use of mechanisms for coordination of interventions with activities financed or cofinanced by the BMZ during the implementation phase (practical harmonisation)	
EF 2.2: What roles do TC and FC interventions play in the SRHR area of intervention, and what comparative advantages and disadvantages can be identified for each?		
<p><i>This question is not assessed. No ACs or indicators are formulated a priori.</i></p>		<ul style="list-style-type: none"> Evaluation synthesis In-person and remote case studies: interviews or focus group discussions, for instance with implementing organisation staff responsible for projects, representatives of projects (TC)/project executing agencies (FC), government and civil society partners, direct target groups

Effectiveness

EQ 3: To what extent do bilateral interventions as a whole contribute to the achievement of the direct objectives of the SRHR area of intervention?		
Assessment criteria	Indicators	Methods
EQ 3.1: To what extent do bilateral interventions in the SRHR area of intervention achieve their objectives?		
AC 1: Assessment of bilateral interventions as effective overall	I 1.1: Assessment of the effectiveness of interventions	<ul style="list-style-type: none"> Evaluation synthesis
EQ 3.2: To what extent do bilateral interventions in the SRHR area of intervention contribute to the achievement of objectives regarding the availability of SRH services, their policy environment and financial barriers to access?		
AC 1: Achievement of direct objectives that relate to SRH services and barriers to access	I 1.1: Achievement of objectives for improving the quality and accessibility of SRH services	<ul style="list-style-type: none"> Evaluation synthesis In-person and remote case studies: interviews or focus group discussions, for instance with implementing organisation staff responsible for projects, representatives of projects (TC)/project executing agencies (FC), government and civil society partners, direct target groups
	I 1.2: Achievement of objectives regarding the availability of SRH products.	
	I 1.3: Achievement of objectives regarding the reduction of financial and legal barriers to accessing SRH services	
	I 1.4: Achievement of objectives regarding policy environment for SRHR	
AC 2: Assessment of bilateral interventions as “without unintended negative effects”	I 2.1: Absence of unintended negative effects of activities to strengthen SRH	
EQ 3.3: To what extent do bilateral interventions in the SRHR area of intervention contribute to the achievement of objectives with regard to the knowledge and attitudes of rights-holders and people in their social environment?		
AC 1: Achievement of direct objectives that relate to SRHR counselling and awareness-raising.	I 1.1: Achievement of objectives for improving the quality and accessibility of SRHR counselling and awareness-raising activities	<ul style="list-style-type: none"> Evaluation synthesis In-person and remote case studies: interviews or focus group discussions, for instance with implementing organisation staff responsible for projects, representatives of projects (TC)/project executing agencies (FC), government and civil society partners, direct target groups
AC 2: Achievement of direct objectives that relate to changed knowledge and changed attitudes to SRHR	I 2.1: Girls and women know and accept SRR (including sexuality education).	
	I 2.2: People in the social environment of girls and women know and accept SRR (including sexuality education).	
AC 3: Achievement of direct objectives that relate to the reduction of gender-discriminatory attitudes	I 3.1: Girls and women recognise gender discrimination and call it into question.	
	I 3.2: People in the social environment of girls and women recognise gender discrimination and call it into question.	
AC 4: Assessment of bilateral interventions as “without unintended negative effects”	I 4.1: Absence of unintended negative effects of activities to strengthen knowledge and change attitudes	

Assessment criteria	Indicators	Methods
EQ 3.4: What factors enable or constrain interventions in achieving their direct objectives?		
<i>This question is not assessed. No ACs or indicators are formulated a priori.</i>		<ul style="list-style-type: none"> Evaluation synthesis In-person and remote case studies: interviews or focus group discussions, for instance with implementing organisation staff responsible for projects, representatives of projects (TC)/project executing agencies (FC), government and civil society partners, direct target groups

Impact, SDGs

EQ 4: To what extent do country-specific financial contributions by the BMZ contribute overall to the achievement of higher-level objectives of the SRHR area of intervention in partner countries?		
Assessment criteria	Indicators	Methods
EQ 4.1: To what extent do interventions in the SRHR area of intervention contribute to strengthening rights-holders and structurally marginalised groups with regard to their SRHR?		
AC 1: Assessment of bilateral interventions as impactful overall	I 1.1: Assessment of the impact of interventions	<ul style="list-style-type: none"> Evaluation synthesis
AC 2: Strengthening of the self-determination of girls and women with respect to SRHR	I 2.1: Self-determined decision-making by girls and women regarding their own bodies, sexuality and reproduction	<ul style="list-style-type: none"> Evaluation synthesis In-person and remote case studies: interviews or focus group discussions, for instance with implementing organisation staff responsible for projects, representatives of projects (TC)/project executing agencies (FC), government and civil society partners, direct target groups
	I 2.2: GBV and damaging practices decrease	
	I 2.3: Gender equality increases	
AC 3: Strengthening of the right to SRH	I 3.1: Maternal and neonatal mortality decrease	<ul style="list-style-type: none"> Secondary data analysis
	I 3.2: Unintended and early pregnancies decrease	

Efficiency

EQ 5: To what extent are bilateral interventions in the SRHR area of intervention implemented efficiently overall and to what extent are objectives achieved efficiently?

Assessment criteria	Indicators	Methods
AC 1: Assessment of bilateral interventions as efficient overall	I 1.1: Efficiency of interventions	• Evaluation synthesis
AC 2: Assessment of bilateral interventions as efficient in specific dimensions	I 2.1: Production efficiency of interventions	• Evaluation synthesis
	I 2.2: Allocation efficiency of interventions	• Evaluation synthesis

Sustainability

EQ 6: To what extent are bilateral interventions in the SRHR area of intervention implemented overall such that their objectives are achieved sustainably?

Assessment criteria	Indicators	Methods
AC 1: Assessment of bilateral interventions as sustainable overall	I 1.1: Sustainability of interventions	• Evaluation synthesis
AC 2: Assessment of bilateral interventions as sustainable in specific dimensions	I 2.1: Actors' and stakeholders' interest in maintaining and ability to maintain positive impacts over time	• Evaluation synthesis • Evidence synthesis

8.3 Timeline of the evaluation

Time frame	Tasks
Conception phase	
Up to 04/2023	Clarification talks and preparation of the evaluation
04/2023	Launch of the evaluation
04/2023 – 06/2023	Drafting of the evaluation concept
06/2023	First meeting of the reference group to discuss the evaluation concept
Inception phase	
06/2023 – 08/2023	Conduct of the preliminary analyses (portfolio and document analyses)
08/2023 – 10/2023	Drafting of the inception report
11/2023	Second meeting of the reference group to discuss the inception report
11/2023 – 12/2023	Finalisation of the inception report
Data collection phase	
11/2023 – 01/2024	Preparation of the case studies (creation and testing of the data collection instruments)
01/2024 – 03/2024	Data collection (case studies), data processing (evaluation synthesis, secondary data analysis, evidence synthesis) and preparation of the scenario analysis
Analysis and synthesis phase	
04/2024 – 05/2024	Cross-study analysis of case study findings and synthesis of all findings, conduct of the secondary data analysis and the evaluation and evidence synthesis
06/2024 – 08/2024	Conduct of the scenario analysis
04/2024 – 10/2024	Drawing up of the conclusions and recommendations
07/2024	Third meeting of the reference group to discuss the provisional findings
Reporting phase	
08/2024 – 10/2024	Preparation of the draft report
10/2024 – 12/2024	Quality assurance and forwarding of the draft report to the reference group
01/2025	Fourth meeting of the reference group to discuss the draft report
01/2025 – 03/2025	Finalisation of the report
03/2025 – 05/2025	Editing and layout of the report
06/2025	Forwarding of the report to the BMZ and subsequent publication
06/2025 – 09/2025	Dissemination and knowledge transfer (including the processing of findings for rights-holders in partner countries)

8.4 Evaluation team and contributors

Core team	Function	CRedit Statement¹⁴⁹
Dr Jan Tobias Polak	Senior evaluator, team leader	Conceptualisation, formal analysis, investigation, methodology, project administration, supervision, visualisation, writing
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Dr Denise Hörner	Evaluator	Conceptualisation, methodology, project administration
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Responsible	Function
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¹⁴⁹ Das CRedit statement (Contributor Roles Taxonomy, <https://credit.niso.org/>) characterises the roles of the DEval employees and externals involved in the evaluation. The CRedit taxonomy distinguishes between 14 different roles, in order to make transparent the specific contribution of each author.

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