

Ex post evaluation – Burundi



Sector: 12230 Basic health infrastructure
Project: Health Sector Programme, Phases III and IV (BMZ No.: 2010 66 919, 2012 67 236*)
Implementing agency: National Programme for Reproductive Health (Programme National de la Santé de la Reproduction (PNSR) (Component 1), Population Services International (PSI) (Component 2)



Ex post evaluation report: 2017

		Phase III (Planned)	Phase III (Actual)	Phase IV (Planned)	Phase IV (Actual)
Investment costs (total)	EUR million	3.036	3.110	3.028	3.234
Counterpart contribution	EUR million	0.036	0.025	0.028	0.028
Funding	EUR million	3.000	3.085**	3.000	3.206***
of which BMZ budget funds	EUR millio	3.000	3.085**	3.000	3.206***

*) Random sample 2016 **) Including residual funds from Phase II totalling around EUR 311,000, discounting around EUR 20,000 which has not yet been disbursed as a result of the development cooperation with Burundi being partially suspended.

Summary: Phases III and IV of the sectoral programme encompassed two components: firstly to promote sexual and reproductive health via the government programme for reproductive health (PNSR - Programme National de la Santé de la Reproduction) (Component 1), and secondly for social marketing activities for HIV prevention via the non-governmental organisation PSI Burundi (Population Services International) (Component 2). Both components focused on providing high-quality, low-cost contraceptives and condoms, as well as supporting information and behaviour change campaigns. In addition to advanced training for managers of decentralised pharmaceutical depots, PNSR held training courses on family planning methods for the staff of health centres.

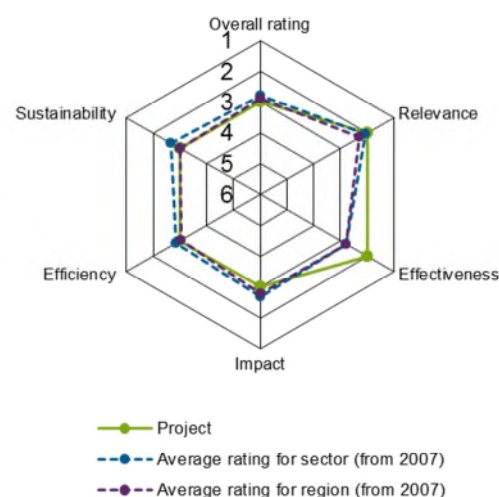
Development objectives: The project objective (outcome) was to change the population's attitudes and modes of behaviour around family planning and HIV/AIDS prevention and to increase the use of modern contraceptives. The aim was for the latter to be achieved firstly with a more efficient and effective supply of contraceptives, and secondly by boosting demand through the information measures carried out during the course of the project. The project's development objective (impact) was to contribute to lowering population growth, improving health and stabilising the country by improving the Burundian population's reproductive and sexual health (dual aims).

Target group: The project's target group was the entire population of Burundi of reproductive age between 15 and 49 years old, especially women (Component 1) and young people (Component 2).

Overall rating: 3 (both phases)

Rationale: The project still has high relevance today with its contribution to limiting population growth in Burundi, a country with above-average population density. Its effectiveness was still good overall, considering the clear improvement in the Contraceptive Prevalence Rate. On the other hand, there were still evident weaknesses in its efficiency and in terms of the social marketing component's impacts, although this was in fact particularly relevant for the development effectiveness due to its focus on the important target group of young people.

Highlights: A particularly noteworthy positive is that it was possible within a relatively short time-frame to appreciably improve the availability of contraceptives in the government health facilities, as well as demonstrably increasing their usage in a society that is strongly influenced by the Catholic Church. It is particularly commendable that, in spite of the political crisis which has persisted since 2015, a follow-up financing package was secured (even if this was still external) and it has been possible to effectively maintain the supply of contraceptives to date.



Rating according to DAC criteria

Overall rating: 3 (both phases)

A joint programme appraisal report, including an anticipated appraisal, was produced for Phases III and IV of the FC project. This was intended to ensure a supply of contraceptives and condoms until the arrival of the follow-up financing that was envisaged. There were no fundamental changes in the measures and objectives between Phases III and IV. The impacts of the individual phases also cannot be isolated from one another, given the short duration of the entire term (four years). The two phases were therefore jointly evaluated and, where possible, separately assessed against the DAC criteria.

Relevance

At the time of the programme appraisal in 2010, the Burundian population grew by more than 3% p.a., as in the preceding years, and the population density rose to around 340 inhabitants per km². Since 90% of the country continued at the same time to live in rural areas and make their living from agriculture, Burundi was reaching the limits of its capacity. The depletion of natural resources that accompanied the growing population pressure enhanced the risk of poverty and usage or distribution conflicts in the country; a setting where unequal access to resources and power had already crucially contributed towards escalating the Tutsi-Hutu conflict and the outbreak of the Civil War in the 1990s. Consequently, a project intended to assist with limiting population growth via increased use of modern contraceptives fundamentally has high development policy relevance, including from today's perspective.

A key cause for the rapid population growth in Burundi was the persistently high fertility rate, which stood at 6.4 children per woman during the PA. The contraceptive prevalence rate was only 18.9%, though it had continually moved in a positive direction in the years beforehand and was only 1.3% among young women between 15 and 19 years of age. At the same time, the family planning needs of 31% of women with a steady partner were going unmet. The maternal and infant mortality rates, which also reflect factors such as access to and quality of family planning methods, had noticeably improved in the preceding years. However, these remained high by international standards (maternal mortality in 2010: between 500 and 800/100,000 live births; infant mortality: between 59 and 88/1,000 live births, depending on the source¹). Similarly, Burundi had a high prevalence of HIV/AIDS at over 3% in the late 1990s. After a continual reduction, this still stood at 1.5% by the time of the appraisal in 2010. This was considerably higher among women in all age groups than among men, and 50% of new HIV infections were contracted by young people under 25. The countries immediately neighbouring Burundi (Democratic Republic of Congo, Rwanda and Tanzania) also had the highest HIV/AIDS prevalence rates in the world (between 5% and 13%). It therefore made sense to address HIV/AIDS prevention alongside the issue of family planning within the scope of the project.

Putting the target groups of women and young people at the heart of the project was extremely relevant, considering women's particular role in terms of family planning, the increased degree to which they are affected by HIV/AIDS, and the low contraceptive prevalence rate among young people. Since contraceptives were still supplied by the public health sector in great measure, it was sensible to take the approach of promoting this (Component 1 via national reproductive health programme – PSNR), while also supporting commercial distribution channels (Component 2 via non-governmental organisation – NGO). At root, the results chain was sound. A strategy would be employed to help curb population growth by reducing unwanted pregnancies and lowering the risk of HIV infection. This would involve providing access to contraceptives and increasing their availability as a result, combining this with awareness campaigns. The method of linking free or low-cost provision of contraceptives, awareness campaigns and training for government health personnel on the one hand with family planning and HIV/AIDS on the other is in line with state-of-the-art standards.

¹ The national Demographic and Health Survey (EDSB II, 2010) and estimates by the UN Maternal Mortality Estimation Inter-Agency Group (MMEIG, 2010), respectively, use different methods to determine maternal mortality.

Ultimately, the programme’s relevance was also apparent in the fact that its objectives were consistent with German and global development policy priorities at the time of the appraisal. Limiting population growth was established as a priority objective in both national anti-poverty strategies (2006-2011, 2012-2016), as well as Burundi’s national “Vision 2025” (2011). Improved family planning and HIV/AIDS prevention are important components of the national policy on sexual and reproductive health (2007), and the social marketing approach is an aim expressly stated in the national strategic plans to combat HIV/AIDS (2007-2011, 2012-2016, 2014-2017). In addition, the project helped to achieve two of the eight Millennium Development Goals (improving maternal health, combating HIV/AIDS), in addition to addressing the “demographic dynamics” focus area in German development policy, which continues to be important.

Relevance rating: 2 (both phases)

Effectiveness

The project objective (outcome) was to change the population’s attitudes and modes of behaviour around family planning and HIV/AIDS prevention and increase use of modern contraceptives. This objective is in line with state-of-the-art standards. Seven indicators were used to review the objective for the ex post evaluation, with indicators 1 to 4 to assess Component 1 and indicators 5 to 7 to assess Component 2:

	Indicator	Status PA	Ex post evaluation
1	a) Contraceptive Prevalence Rate (all modern methods, women 15-49 years of age) b) Contraceptive Prevalence Rate (all modern methods, young women 15-19 years of age)	a) Status PA (2010): 18.9% b) Status PA (2010): 1.3%	a) Status (2016): 42.5% b) Status (2016): 21.2%
2	Number of regular female users of modern contraceptives (all modern methods)	Status PA (2010): 282,591	Status (2015): 664,725
3	Number of government health facilities with contraceptives in stock	Status PA (2010): <5% Target value PA (2014/15): <2%	Status (2016): 0.6%
4	Number of women in a steady relationship whose needs for contraceptives were unmet	Status PA (2010): 31% MDG target value (2015): 15%	Status (2016): 30%
5	Number of young people (15-24 years of age) who used a condom the last time they had sex with a casual partner.	Status PA (2009): 57.2% Target value PA (2014/15): 60%	Status (2014): 58%; status (2016, different data source): 50.8% (male); 32.1% (female)
6	a) Number of condoms sold by PSI between July 2011 and December 2014 b) Number of condoms sold by PSI/year	a) Status PA (2009): 0% Target value PA (late 2014): 10 million b) Status PA (2010): 1.5 million/year	a) Status (2014): 9.5 million b) Status (2016): 4.3 million/year

These indicators are fundamentally suitable as a means of showing changes in the use of contraceptives and in behaviour during the course of the awareness campaigns.

Indicator 6, in fact, is an output indicator that does not show the actual use of the condoms that are sold, nor the extent to which the target group is supplied with condoms overall in the sense of the total market approach (currently state-of-the-art). Nonetheless, this can be used as a decent proxy indicator for the measure’s outcome, as we can assume that a condom bought with money will normally go on to be used.

Given that there are hardly any condoms commercially distributed in Burundi other than those sold by the NGO, the indicator is simultaneously a good reflection of the commercial availability of condoms and the use of commercially distributed condoms.

The trends in Indicators 1 to 3 and their target achievement levels indicate the positive impacts of Component 1's activities to improve the logistical system for contraceptives and the advanced training of staff at the government health facilities in the area of sexual and reproductive health. Moving on to consider Indicator 4, it also becomes clear that the proportion of women seeking to use protection but unable to meet this need has stagnated since the PA. Reasons behind this include not only access to and availability of contraceptives, but also women's attitudes around contraceptive use.

In terms of Component 2, Indicator 6 demonstrates the positive trend in sales of social marketing condoms, which manage to be increased year on year despite the substantial amount of condoms distributed for free. On the other hand, Indicator 5 shows that the desired changes in behaviour among young people have not yet been made even though the social marketing activities have been continued until the present by means of other financing packages (see "Sustainability" criterion). This raises questions about the efficacy of the awareness campaigns that were implemented. However, it must be noted that changes in behaviour regarding contraceptive and condom use can only take place very gradually in Burundi, partly on account of the strong enduring resistance and influence on the part of the church. In addition, work to raise awareness has become more difficult during the political crisis (see "Sustainability" criterion).

In view of Component 1's very positive results in terms of contraceptive provision and use, as well as the encouraging sales trend with the social marketing condoms, we still rate the project's effectiveness as good.

Effectiveness rating: 2 (both phases)

Efficiency

The project was implemented in two components by two different project executing agencies. The implementation costs were therefore relatively high overall (around 46% of total costs). Nonetheless, this two-pronged execution structure fundamentally made sense at the time of the appraisal, since it was used to appropriately satisfy the needs of different target groups. Among women using protection, 87% obtained their contraceptives (all modern methods including condoms) at the public health facilities. Young people between 15 and 24 make up close to 20% of the Burundian population. Members of this cohort use especially few contraceptives, though at the same time they are particularly sexually active and represent 50% of new HIV/AIDS infection cases. However, to date, this group has been hard to reach through government health facilities, having very rarely been independently motivated to visit these for prevention purposes. At the same time, there have scarcely yet been any health facilities geared to the particular needs of young people. Additionally, only close to 40% of the women using protection acquired condoms as their sole form of modern contraception via the public sector. This stands in contrast to other contraceptives (e.g. the pill, implants, IUDs), which at least 80% of the women obtained at the government facilities. On the other hand, with experience from other countries in mind, it was plausible that higher efficiency of condom distribution would be achieved in the medium term via social marketing than via government procurement and distribution channels. For this reason, it was also appropriate during the PA to promote the development of social marketing in a dedicated project component.

Approximately three-quarters of the available funds were invested in Component 1 and a quarter in Component 2. This is close to the original plans. On the one hand, this division of the funds appears somewhat unbalanced considering the relevance of the target group of young people and the investments in the awareness campaigns within Component 2, which can ultimately be presumed to be too low. On the other hand, in terms of sustainability potential, it made sense to invest a large portion of the funds into the PSNR component, thus helping to strengthen the health sector in Burundi for the long term.

The efficiency within Component 1 can be rated as relatively good. By and large, the distribution of costs is in keeping with the budget lines in the design. The component's implementation costs (around 36%) are also well within limits and in line with the planned costs with regard to the range of activities (developing the national contraceptive logistics system, giving advanced training to staff, providing equipment to the health facilities, spreading awareness among the population, sector coordination) and the good results

achieved overall. In addition, extending the available funds in Component 1 until the follow-up financing made it possible to maintain the PSNR's capacity for action and the effective supply of contraceptives for a year.

On the other hand, the implementation costs of Component 2 (operating and distribution costs) were not only higher than planned at around 57% of its total costs; they were definitely too high. This was compounded by the high international staffing costs of the NGO itself, which were relatively higher at close to 16% than the consulting costs in Component 1 (around 12%). In contrast, only around 15% of the expenditure was invested in marketing and awareness measures, which presumably helps to explain the low impacts in terms of behavioural changes. Over 39 months, the social marketing NGO sold around 9.5 million condoms in total, which is equivalent to 79,620 couple-years of protection (CYP). The programme costs (including administrative costs) were around EUR 20/CYP (around EUR 19/CYP when sales revenues are factored in), making them very close to the average amount to be expected in the context of Africa (around EUR 18). Compared with the first two phases of the project, in which the costs per CYP stood at EUR 38 and 50/CYP respectively, this amounts to a significant improvement.

The sales revenues covered 3.8% of the total costs and 6.2% of the operating costs. An improvement was also successfully made here in comparison with Phase II when these figures were only 0.6% and 2.2% respectively. However, the values are very far removed from what is to be expected in the African context in social marketing projects, especially in terms of the operating cost coverage, so they are unsatisfactory in this respect. The slight improvement in cost efficiency from Phase II was achieved for reasons including an increase in the sale price. A three-pack of the social marketing condoms, sold at an equivalent of EUR 0.05, was more than twice as expensive as in Phase II of the project. This meant that one CYP (120 items a year) cost consumers the equivalent of around EUR 2.10. According to the Chapman Index to measure ability to pay, one CYP should not cost more than 1% of annual per capita income. On average, the per capita income in 2014 in Burundi was around EUR 811. The CYP costs for the Burundian consumers were significantly below this threshold at 0.26%.

Despite Component 2's insufficient outcome, we still rate the efficiency as satisfactory on account of the good results from Component 1, which used three-quarters of the funds.

Efficiency rating: 3 (both phases)

Impact

The development objective (impact) was to make a contribution to reducing population growth by improving sexual and reproductive health. In view of the fragile context in which the project existed, it was intended at the same time to contribute to stabilising the country following the end of the Civil War (dual aim). The fertility rate, HIV prevalence and maternal mortality were defined as indicators. If the rapid population growth is decreased by way of a lower birth rate, potential for conflict over the use of scarce resources can be limited, the risk of fault lines for conflict from the past being reopened can be lessened, and poverty can be reduced. If the spread of HIV/AIDS within the population is limited, human capital and the economic performance capacity of the country can be safeguarded. The strengthening of government health services, reflected in the reduced maternal mortality, can contribute to restoring the population's confidence in the ability of the government to act in a post-conflict context such as in Burundi. This is a long-term contribution to the stability of the nation. The changes in the ultimate objective indicators between the appraisal and ex post evaluation are summarised below.

At the PA, almost 90% of the women using contraceptives received these at government health facilities. Since the project crucially assisted financially and institutionally with the supply of contraceptives via PNSR and government health facilities, we can assume that it made an important contribution to lowering the fertility rate. Nonetheless, this remains too high at 5.5 children per woman to reach the reduction in population growth to 2% a year by 2025, which was declared a priority goal by the Burundian government.

Indicator	Status/target value at project appraisal	Ex post evaluation
Fertility rate	Status PA (2010): 6.4	Status (2016): 5.5
Maternal mortality rate	Status PA (2010): 800/100,000 live births. At hospital (2007): 117/100,000 live births	Status (2015): 712/100,000 live births At hospital (2016): 169/100,000 live births
HIV prevalence rate	Status PA (2010): 1.5% (contemporary statistics from UNAIDS for 2010)	Status (2016): 1.1%

The promising trend in HIV/AIDS prevalence, which was still above 3% in Burundi in the late 1990s, has continued since the PA – albeit more slowly. This is 1.1% today. According to UNAIDS statistics, the absolute number of people infected with HIV has also dropped since 2010 from 93,000 to 84,000. Between the appraisal and final review, only a quarter of the condoms that were given out or sold were distributed with the project’s assistance via PNSR (around 5%) or the social marketing NGO (around 20%). The vast majority of condoms were provided free of charge via the national AIDS programme, CNLS (Conseil National de Lutte contre le Sida) and its structures on a community level. Furthermore, the HIV awareness measures implemented during the project by the social marketing NGO only had a comparatively small impact and were small in scale compared with the campaigns carried out by CNLS. We can therefore rate the project’s contribution to reducing the prevalence of HIV as being on the smaller side.

On the other hand, the maternal mortality is worrying, continuing to be very high² and since even increasing in the hospitals. This points to the insufficient access to high-quality family planning and care. Consequently, the advanced training of health personnel carried out in the course of the project and the medical equipment for the government health facilities have not yet had a demonstrable effect on reducing maternal mortality.

Against this background, we can reasonably surmise that the project at least makes a certain contribution to Burundi’s stability in the longer run by reducing the fertility rate. However, the persistently high maternal mortality jeopardises women’s confidence in the government health services and, in turn, their motivation to take advantage of family planning methods there, as well as jeopardising their overall confidence in the ability of the government to act. This is detrimental to stability.

Impact rating: 3 (both phases)

Sustainability

Both project executing agencies continue to depend on external funds to carry on their activities. Both components of the project have since been continued with financing from the Netherlands and support from UNFPA (Component 1) and with the same NGO (Component 2). The financial sustainability of the project therefore appears weak due to the continuing reliance on external funds. However, especially in the highly fragile context in the country at present, we can rate the safeguarding of follow-up financing and continuation of the previous activities as extraordinarily positive and as an important contribution to the sustainability of the project’s impacts.

As far as the institutional sustainability of Component 1, a comprehensive study from 2016 shows relatively good results in terms of the availability of different contraceptives in the health facilities. Over 90% of the facilities had at least three modern forms of contraception. The contraceptive logistics, which continue to work in a satisfactory manner today, indicate that PNSR’s coordination office is capable of effectively organising the procurement and distribution of contraceptives. Likewise, this situation reflects the sustainable impacts of the advanced training which PNSR provided to managers of the pharmaceutical depots at district level during the project. However, one factor contributing to the continuation of the positive impacts

² According to estimates by the UN Maternal Mortality Estimation Inter-agency Group (MMEIG, 2015). The final results of the national Demographic and Health Survey (EDSB III, 2016), including data on maternal mortality, have not yet been released.

is that PNSR has received external support to date, especially in contraceptive logistics (even though this is not true to the same extent as before). Within the scope of the project, PNSR's coordination office has also recently been strengthened in its strategic role as a coordination centre within the "sexual and reproductive health and rights" sector. The sector and donor coordination by PNSR improved significantly during this time. The current financing no longer envisages a component of this type, nor does it support PNSR with its operating costs any more. Since the Burundian president unconstitutionally ran for a third term of office in 2015, the nation has entered a socio-political crisis featuring violent protests and acts of political persecution. It is increasingly isolated internationally. It is therefore difficult today for PNSR, which has since become even weaker in terms of human and financial resources, to develop the leadership necessary to coordinate the complex sector. The lack of a sufficiently clear distinction to date between its coordinating mandate and its operational roles further lowers PNSR's institutional performance capacity, despite the fundamental presence of professional skills.

In Component 2, the NGO clearly has the necessary capacities and skills to maintain the yearly condom sales of at least 3 million items. Nonetheless, the institutional sustainability of Component 2 is only satisfactory to a limited degree, as the NGO has not yet fulfilled the requests made during the project to record and analyse the impacts of the marketing and awareness campaigns for behavioural changes among young people. There is therefore doubt as to whether the NGO has sufficient skills to adequately design the awareness campaigns. Additionally in terms of sustainability, the question remains of how likely the project's positive impacts so far are to continue. In light of the political crisis which has persisted since 2015, the omens for this are not particularly good, despite most of the measures continuing. The funds provided for the health sector in general are diminishing, meaning that they also diminish for PNSR, the devolved health services and the health facilities. The cancellation of bonuses and decrease in supervision efforts by PNSR and devolved services have acted to reduce the health workers' motivation. Health personnel have left the country and clinics have already been closed. The quality of the services for sexual and reproductive health and rights (SRHR) and related training of health personnel continues to be a major challenge. In 2016, only around a third of the staff at all health facilities was trained to consult on contraceptives and their use. In general, willingness to make clear decisions is on the wane at the Ministry of Health. There have already been shortages of medications at the depots, which have led to rationing, especially in the case of free treatment for pregnant women and children. It is quite possible that there will also be shortfalls in contraceptives in the future: almost EUR 13 million in funding is still needed to replenish the depots by 2022.

Working conditions have also become more difficult for the social marketing sector. Since the start of the crisis, increased pressure has been put on NGOs. There are limits on the NGO, specifically on the content of its awareness efforts for HIV prevention. Radio transmissions for awareness purposes are broadcast less often, as there are hardly any private radios. The security situation has also on occasion made it impossible to keep selling condoms in certain districts of the city of Bujumbura. As the crisis has endured, the private sector has also come under economic as well as political pressure, meaning that in particular small private (condom) sellers are increasingly retreating from the market. Growing poverty in the population raises the question of the extent to which the target group is still willing and able to spend money on condoms at all. This is aggravated by the fact that a Catholic Church largely condemning family planning continues to have large influence within the Burundian population, which is presumably even stronger at times of crisis. Rumours that have spread about the negative effects of using contraceptives have even taken on a political tone in some cases.

Overall, it is clear that the positive trends within the SRHR area in Burundi could very quickly be reversed under current conditions. However, the supply of contraceptives and condoms via public and private channels has been sustained until the present, which we can rate as a very positive accomplishment in this type of context.

Sustainability rating: 3 (both phases)

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

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

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

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

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

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

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

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

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

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