Ex post evaluation – Guinea

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Sector: Family planning/STD control incl. HIV/AIDS (CRS Codes 13030/13040)
Project: Social Marketing I and III, BMZ No. 2001 65 688*, 2008 65 501 and AIDS prevention as a cross-sectional task (II), BMZ No.: 2001 65 696
Programme executing agency: Ministère de la Santé et de l'Hygiène Publique

Ex post evaluation report: 2014

		Phases I-III (Planned)	**Phases I-III (Actual)
Investment costs (total)	EUR million	25.60	22.40
Sales revenue	EUR million	2.20	1.70
Counterpart contribution	EUR million	3.90	0.70
Funding	EUR million	19.50	20.00
of which BMZ budget funds	EUR million	19.50	20.00

*) Random sample 2013
**) Sum of 3 phases evaluated (see next page for detailed list)

Description: The FC measures were designed to ensure the entire population receives a better supply of inexpensive and quality-assured condoms as well as hormonal contraceptives (pills, contraceptive injections), while targeted awareness campaigns were to increase demand for these products. In Phase III, the awareness measures were supplemented with the topics of preventing the circumcision of women and girls as well as treating diarrhoea in children under five years of age.

Objectives: The ultimate objective was to help reduce the HIV infection rate as well as improve reproductive and family health. This was to be achieved through increased use of condoms and contraceptives (project objective). To achieve this the population was to have better access to inexpensive and quality-assured condoms and hormonal contraceptives, a measure supported by awareness campaigns focused on the target group.

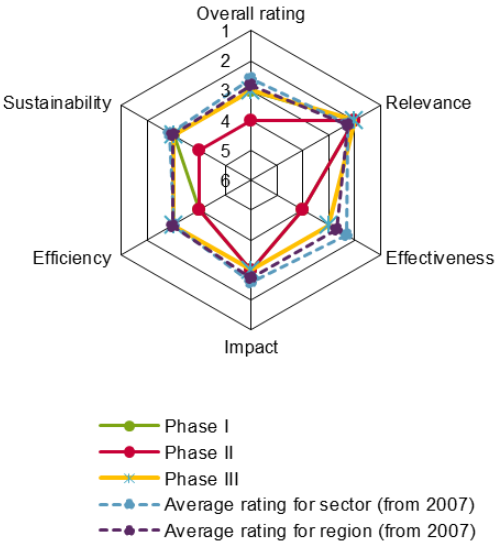
Target group: The target group was the sexually active population in Guinea, concentrating on groups at an increased risk of HIV infection (including young people, soldiers, miners, lorry drivers, prostitutes). Preventing the circumcision of women and girls is aimed particularly at religious and traditional leaders as well as those working in health-care centres and schools.

Overall rating: Note 3 (Phases I and III); 4 (Phase II)

Rationale: The positive relevance and sustainability result in a satisfactory evaluation, despite the unsatisfactory effectiveness and efficiency of Phase I. The inadequate sustainability of Phase II, however, produces an unsatisfactory overall rating. The improvements implemented in Phase III result in an improved rating.

Highlights: The three phases were implemented under extremely difficult conditions (military coup in 2008, massacres in 2007 and 2009), where awareness and marketing campaigns were carried out for the target groups that brought about changes – albeit moderate ones – in the behaviour of younger generations in particular (increased use of contraceptives).

The focus of the project shifted slightly from phase to phase whilst maintaining the same objective: (I+II) focus on HIV prevention by distributing condoms, whereby Phase II relied initially on local structures; Phase III concentrated more closely on reproductive health (including the still very prevalent practice of circumcising women and girls).



Rating according to DAC criteria

Overall rating: 3 (Phases I and III); 4 (Phase II)

Phase I is rated as just satisfactory, Phase II is rated unsatisfactory and Phase III is rated satisfactory.

General conditions and classification of the project

The ex post evaluation was carried out for three projects that were initiated within the same timeframe and have related content. The Social Marketing project with BMZ number 2001 65 688 was carried out between January 2004 and June 2009 and is hereinafter referred to as Phase I. The "AIDS prevention as a cross-sectional task" (BMZ number: 2001 65 696) referred to here as Phase II was carried out with a regional focus on Middle Guinea. It was launched in November 2003 and merged with Social Marketing I after 34 months (September 2006). The "Social Marketing III" project (BMZ number: 2008 65 501) was implemented between July 2009 and December 2013.

Breakdown of total costs in all three phases

		Phase I (Planned)	Phase I (Actual)	Phase II (Planned)	Phase II (Actual)	Phase III (Planned)	Phase III (Actual)
Investment costs total	in EUR	15.1	11.7	2.5	2.5	8.0	8.2
Sales revenue	in EUR	1.2	0.5	--	--	1.0	1.2
Other donors**	in EUR	3.9	0.7	--	--	--	--
FC, BMZ funds	in EUR	10.0	10.5	2.5	2.5	7.0*	7.0

* Anticipated appraisal: due to political difficulties, EUR 2 million was initially approved for 2009-2011; in 2011 an additional EUR 5 million was approved until 2013..

** This only affects the co-financed amount for the HIV and Family Planning project

Relevance

With different emphases, the three phases encompassed the topics of HIV prevention as well as reducing population growth, both priorities set by the Guinean state. The need for health education as well as prevention for target groups in the whole country was tackled via social marketing, a method that can function close to the target group but remote from the state – which is particularly important for the conflict-ridden region of Guinea. With reference to experience from a previous project (National Family Planning Programme, BMZ number: 1994 65 279), which supported public health centres and was considered not to have been a success, Phases I-III concentrated on priority target groups and their needs based on research that took the specific social and cultural aspects into account. The Ministry of Health (MSHP) welcomed these initiatives and underlined that social marketing as well as prevention with a focus on at-risk groups through NGOs was far more effective than through public institutions

The three phases blend in with a range of national policies: the "Politique Nationale de Développement Sanitaire 2003-2012", the Poverty Reduction Strategy Papers (PRSP 2007-2010; 2011-2012; 2013-2015), which aim to reduce maternal and child mortality, and additional "Feuilles de Routes" (e.g. reduction of maternal, infant and child mortality 2012-2015). The projects contribute to MDG 4 (reduce child mortality), MDG 5 (improve maternal health), MDG 3 (promote gender equality and empower women) as well as MDG 6 (combat HIV/AIDS, malaria and other diseases) and therefore underlie priorities of the German government. Indirectly they also influence the improvement of MDG 1 (eradicate extreme poverty and hunger).

Phase I initially focused on the marketing of subsidised condoms and initial guidance about HIV prevention for the target group. Phase II concentrated on specific groups at risk of HIV, such as adolescents, soldiers, miners and lorry drivers in a defined area (Middle Guinea). Only once the HIV epidemic was assumed to be in decline (see overarching developmental impacts) was Phase III able to focus mainly on

the topic of reproductive family health. The three phases were conceptually well-integrated and developed according to the needs and conditions of the unstable environment. Overall, the project's relevance can be assessed as good in all three phases.

Relevance rating: 2 (Phases I-III), good

Effectiveness

The project objectives for Phases I and II were an improved supply of inexpensive, quality condoms and hormonal contraceptives for the Guinean population as well as a sustainable increase in demand for the respective products through awareness campaigns directed at the target group. Phase III complemented this by improving knowledge about the consequences of circumcision (female genital mutilation, FGM) and a change of attitudes towards this topic that aimed to reduce circumcisions in the medium to long run.

The following indicators illustrate the objectives of the three phases. Indicators 3, 4, 6 and 7 at the Outcome level that comply with today's state of the art are particularly important for the success evaluation.

Indicators for FC measure objective/planned	Ex-post evaluation/actual
1. Increase in sale of condoms Phase I: increased by 11 % p.a.; initial value 2001: 6.1 million p.a.; target value: 50 million p.a. Phase III: increased by 5% p.a. from 60,000 CYP in 2009	 (I) Nearly achieved (48.6 million units or 97 % of the target value) (III) Significantly exceeded (289,061 CYP)
2. Sales of oral and injectable contraceptives Phase I: increase by 1 5% p.a.; initial value 353,000 cycles in 2001; target value: 3.5 million cycles (oral 0.353 million cycles p.a. to 3.5 million; injections from 87,700 to 0.9 million.) Phase III oral: increase by 5 % p.a.; initial value: oral contraceptives 35,000 CYP; injections 30,000 CYP	 (I) Not achieved (2 million oral, 0.58 million injections or 74% of the target value) (III) Achieved (116,243 CYP oral) or significantly exceeded (total of 185,032 CYP injections)
3. Phase III, Prevalence of modern contraceptives: increase by one percentage point p.a.; initial value 2005: 6.8 % (EDS*)	(III) Not achieved: 7 % (EDS 2012) – but considerable deviations depending on age group: see below.
4. Phases I and II, Use of condoms in at-risk groups: Increase in proportion of at-risk groups that indicate having used a condom during last intercourse (+ 20 percentage points)	(I-II) Achieved: military: from 26.7 % (2003) to 51.6 % (2010); miners: from 30.1 % (2005) to 56.4 % (2010); (I-II) Negative development for lorry drivers: from 55.9 % (2005) to 49.1 % (2010)
5. Phase III: increase in sale of preventive products for diarrhoeal diseases (SurEau 300,000 bottles) and from 2012 OraselZinc (331,000 boxes)	(III) Achieved: 1.56 million bottles of SurEau and 790,000 boxes of OraselZinc
6. Phase III, genital mutilation of girls**: - Proportion of women that do not intend to have their daughters circumcised: 34 % (2009) - Proportion of men who indicate that Islam does not dictate female circumcision: 31 % (2009)	 (III) Positive trend: 40 % (TRaC Study, 2011) (III) Positive trend: 45 % (TRaC Study, 2011)
7. Phase III, Contraception/Treatment of diarrhoeal diseases - Proportion of women with children under 5 years that are familiar with the risks of unclean drinking water and know how to protect themselves against it (+10 % p.a.). Initial value: 21 % (TRaC Study, 2008)	(III) Significantly exceeded: 96 % (TRaC Study, 2011)

*) EDS, Enquête Démographique et de la Santé de Guinée; **) Please note that these are the personal opinions of respondents. Significantly more than 90 % of all females in Guinea are still circumcised (2012).

Indicator number 3: contraceptive prevalence (modern methods), differentiated by age group

	2004/2005	2008	2012/13	Comments
Prevalence of women between 15 and 49 years of age (%)	7.7 (1) 6.8 (4)	9.8 (2)	17 (3) 7.0 (5)	Values of TRaC studies not consistent with official statistics (EDS), possibly due to different selection of respondents
Prevalence of women between 20 and 24 years of age (%)	9.1 (4)		11.2 (5)	A significant trend among the age groups indicates a clear increase in the utilisation of contraceptives by young and unmarried women
Prevalence of women between 25 and 29 years of age (%)	7.8 (4)		9.8 (5)	
Prevalence of women that are not married, but sexually active (%)	36.3 (4)		41.1 (5)	

(1) KAP Study FP 2004; (2) TRAC Study FP 2008; (3) TRAC Study FP 2012; (4) EDS 2005; (5) EDS 2012

Altogether, the project implementation period was marked by considerable political instability as well as regional conflicts, which significantly limited the means of action for the projects. Not all the indicators could be achieved. Additionally, the results illustrate the different focuses of the three phases: Phases I and II concentrated primarily on HIV prevention – with unsatisfactory results for family planning indicators as a result – while the target indicators in Phase III (focus on family health with increased importance on reducing circumcision among girls and women as well as combating diarrhoeal diseases) showed initial improvements regarding the contraceptive prevalence rate of young women and the topic of circumcision. Furthermore, the activities and sales figures of Phase III, where subsidised products were introduced to improve children's health, clearly exceed expectations – confirming the high needs-driven orientation. Almost 20 % of FC funds in this phase benefited this component. Summing up, Phases I and II are assessed as being no longer satisfactory, while Phase III – due to its particularly successful initial attempts in combating diarrhoeal diseases – is assessed as wholly satisfactory.

Effectiveness rating: 4 (Phases I and II) unsatisfactory; 3 (Phase III) satisfactory

Efficiency

Phase I was delayed for two years as the predecessor project was extended with residual funds. The implementation lasted 66 months (planned duration: 60 months). Phase II was implemented between July 2009 and December 2013. Phase II was launched in November 2003 with a one-year delay (due to reconciling the concept with Guinean partners), and owing to significant inefficiencies (including the overly complex setup of local capacities) it was integrated into Phase I – implemented at the same time – after 34 months).

The politically unstable situation caused higher overall costs (staff, security). Product and marketing-related costs per Couple Year Protection (CYP) were nonetheless around the mean of the years 2004-2008 at 15.6 EUR/CYP (average product mix: condoms, oral and injectable contraceptives), a rather average value by comparison. In addition, costs were almost cut in half between 2009 and 2012 to nearly 8 EUR/CYP. The increased use of injectable contraceptives (from 36,500 CYP in 2008 to 73,000 in 2012) made a significant contribution to this improvement. Phase III was therefore more efficient than Phase I, but not least due to the previous marketing in Phase I, which raised awareness for these products among the target groups and therefore created additional demand. However, with this indicator it has to be considered that the total costs of the project have been broken down on these sold products. The result is that, increasing product-independent education, as demanded by the modern state of the art (total market approach), has a negative impact on this indicator.

Public health centres have also improved their family planning services. With the help of the three projects, around 300 employees were educated in reproductive health and a wider range of products was provided (IUD, birth control implants, injectable and oral contraceptives, condoms). Moreover, public health centres now offer social marketing products in addition to generic products for family planning. The

private sector is starting to get involved in developing the market for condoms. This is also increasingly the case for drinking water disinfection:

Market shares	Social Marketing 2008/2012	Public 2008/2012	Private Sector 2008/2012
Condoms	96 %/70 %	4 %/21 %	0 %/9 %
Oral contraceptives	65 %/no info	35 %/no info	-
Injectable contraceptives	30 %/52 %	70 %/48 %	-
Re-hydration salt	100 %/100 %	-	-
Drinking water disinfection (SurEau)	96 %/80 %	-	4 %/20 %

The retail prices of subsidised social marketing products are determined based on the willingness to pay, calculated by research studies, and adjusted to general inflation as required. They largely kept pace with real price development (inflation 2005 - 2013: average of 19.5 % per year, World Bank):

Development of prices in GNF*	2004	2009	2013*
Condoms (3 pieces)	300	500	1000
Oral contraceptives (one monthly cycle)	700	1000	2000
Injectable contraceptives (three monthly cycles)	1000	2000	3000
Drinking water disinfection (150 ml)		3000	5000
Re-hydration salt (21.8 mg)			5000

*Practical reasons advocate units of 1000, as smaller GNF bank notes are rarely found

The Chapman Index[1], provides information about the cost adequacy of a CYP for the final consumer, in 2008 it totalled 3.63 EUR/year/person and in 2013 the sum of EUR 6.69. The retail price of all subsidised contraceptives was below this threshold value, sometimes significantly (for instance, 2012: oral contraception 1.67 EUR/year, condoms 4.4 EUR/year). Therefore they are easily accessible for the poorer population of Guinea and in some cities even slightly over-subsidised.

The staff of the social marketing organisation that implemented the project was reduced from 54 to 37 employees during the implementation period (today: all local employees, except for two management positions), as was the number of major customers distributing non-pharmaceutical products (including condoms, re-hydration salt), which fell from 300 (Phase I: 2009) to 9 wholesalers (Phase III: 2011-2013). Both measures contributed to better efficiency and an improved sales structure. Sales of pharmaceutical products (oral and injectable contraceptives) are coordinated by only five pharmaceutical wholesale companies nationwide.

The cost recovery ratio (total cost/sales revenue) remained on average at almost 8 % for the duration of the three phases. This can be ascribed to a very low cost recovery ratio in Phase I (barely 4 %). Phase III presents a slightly better cost recovery ratio with about 11 %.

Summing up, Phases I and II are rated as no longer satisfactory, especially due to their inefficient parallel structure and the rather inefficient sales system; Phase III, which presents significant improvements in this respect, is rated as satisfactory.

Effectiveness rating: 4 (Phases I and II) unsatisfactory; 3 (Phase III) satisfactory

Impact

The aim of the three projects was to help reduce the HIV infection rate and improve reproductive and family health. The following indicators are used for the assessment:

[1] The Chapman Index is calculated at 1% of GDP per capita

Indicator	Situation at ex post evaluation
Reducing HIV/AIDS prevalence: - General average 2005: 1.6 % (1.3-1.9) - At-risk group: prostitutes (2001): 42 % - At-risk group: long-distance lorry drivers (2001): 7 % (UNAIDS estimate)	Decreasing trend: - 1.5-1.7% (stable according to CNLS, 2010); estimate for 2012: 1.3 % (UNAIDS)* - At-risk group: prostitutes (2009): 33 % - At-risk group: long-distance lorry drivers (2009): 6 % (UNAIDS estimate)
Reduction of birth rate - 6.3 children/woman (2002)	Slowly decreasing trend: - 5.7 children/woman (2005) - 5.1 children/woman (2012)

*) Roughly 60% of those infected with HIV receive antiretroviral medication (ART), which prolongs life expectancy (UNAIDS, 2013).

HIV prevalence as well as birth rates are making positive progress. The acceptance of social marketing products within the population is also high: “SurEau” for example is taken on trips to disinfect water; “Prudence Plus” generally stands for condoms, and the same holds true for the “Planyl” pill; these conclusions were drawn when interviewing target groups in the country. During Phase I it was not common to show condom packages in stores, but the situation has changed drastically thanks to marketing and communication activity, and they are now displayed openly.

Almost all Guineans (98 %) have already heard of HIV, and 24 % (2012) as opposed to 16 % (2007) now have in-depth knowledge about it, and know for example about the stigmatisation of HIV-positive people, which can be attributed amongst other things to interpersonal communication with “educateurs pairs” (CNLS information). As regards family planning, only AGBEF (Association Guinéenne pour le Bien-Etre Familial) operates with several clinics (supported by the IPPF) that also conduct awareness campaigns to a minor degree. Given the plausible causal chain, it can be assumed that the project contributed to MDGs 4, 5 and 6.

Donors have emphasised the need for a national contribution to reproductive and family health several times, but this did not happen yet. Between 2008 and 2011 the FC projects contributed significantly to reproductive and family health (total costs for reproductive health: USD 3.7 million; of which FC: 37 %; USAID: 15 %; UNFPA: 32 %)[2]. According to the Comité National de Lutte contre le SIDA, the importance of providing education on and selling condoms cannot be emphasised enough when it comes to stabilising HIV prevalence, as non-governmental frameworks are more credible for groups engaged in risky sexual behaviour.

Due to the better prevention of sexually transmitted diseases and HIV, the projects were able to avert additional individual distress caused by disease and death, high costs for treatment and care (which are mostly a burden on women) and extra cost to the economy arising from the absence of employees at work. Furthermore, based on the sales figures of infant and child health products that are beyond all expectations (including re-hydration salt), it can be assumed to have made a positive contribution to infant and child health

Impact rating: 3 (Phases I-III), satisfactory

Sustainability

The Ministry of Health (MSHP) has a “Plan Stratégique de Sécurisation des Produits de la Santé de la Réproduction en Guinée 2013-2017“ (the previous plan covered the years 2008-2012). Social marketing products are included in this strategic plan and constitute the most important elements of family planning measures. Financial sustainability remains problematic though because the Guinean state does not seem to be able to at least take on the spending for improving reproductive and family health. According to UNFPA, only 2.5 % of the state budget in Guinea is currently used for the health sector (in contrast to the planned figure of 7 %).

The rising sales of social marketing products prove that consumers are willing to pay up a certain amount from their own pockets. In Phase III around 11 % of the total costs were covered by sales revenues. Nevertheless, educational and sales activities will still be dependent on substantial external financing in the future to keep subsidised products accessible for the poorer population as well.

2 Source: Rapport de l’analyse de la situation de la sécurité des produits contraceptifs et estimation des besoins en contraceptifs du secteur public de la Guinée 2012-2013. USAID/DELIVER PROJECT, June 2011, released April 2014

The institutional sustainability is characterised by a social marketing organisation, which has been active in Guinea since 1991 and is now mainly composed of local employees. The social marketing organisation and the Ministry of Health work closely together. HIV prevention/reproductive health measures are firmly established in the ministry's strategic planning and are an integral part thereof. The mainstreaming approach implemented in Phase II, however (in collaboration with the education sector and local NGOs), has not proven to be institutionally sustainable. This was the reason for integrating this phase into the parallel Phase I (after about 34 months; EUR 1.3 million).

As illustrated by behavioural analyses (KAP studies), the behaviour of the younger generation regarding reproductive and family health changed slightly (2005: contraceptive prevalence of 9.2 among 20-24 year olds; 2012: 11.2 %). Condoms and contraceptives are being bought in increasing numbers. Nevertheless, these campaigns have to be continued to embed the information in the minds of subsequent generations too and to make the campaigns sustainable. So far this has only taken place through measures funded externally.

Circumcision is a social and cultural phenomenon, which is still deeply embedded in society. This cannot be changed over a short period of time. The fact that several opinion leaders have raised the topic in civil society debates and that the topic is being discussed intensively in society is encouraging

Sustainability rating: 3 (Phases I and III) satisfactory; 4 (Phase II) unsatisfactory

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

Ratings level 1-3 denote a positive assessment or successful project while ratings level 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. Ratings 1-3 of the overall rating denote a "successful" project while ratings 4-6 denote an "unsuccessful" project. It should be noted that a project can generally be considered developmentally "successful" only if the achievement of the project objective ("effectiveness"), the impact on the overall objective ("overarching developmental impact") and the sustainability are rated at least "satisfactory" (rating 3).