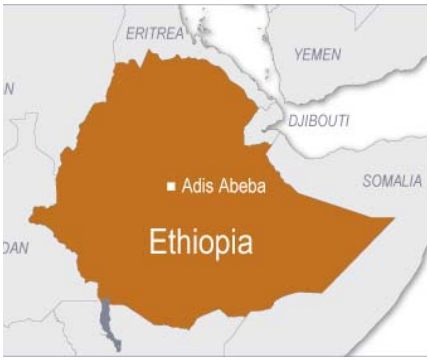
Ex Post-Evaluation Brief

ETHIOPIA: Family Planning and HIV Prevention I and II



Programme/Client	Family Planning and HIV Prevention I and II 1998 65 163, 2002 66 197*	
Programme executing agency	Ministry of Health, Department of Planning and Programming	
Year of sample/ex post evaluation report: 2012/2012		
	Appraisal (planned)	Ex post-evaluation (actual)
Investment costs (total)	EUR 5 million (phase I) EUR 6 million (phase II)	EUR 2.73 million (phase I) EUR 6 million (phase II)
Counterpart contribution (company)	EUR 2.56 million (ph. I) EUR 3 million (phase II)	EUR 0.17 million (phase I) EUR 3 million (phase II)
Funding, of which budget funds (BMZ)	EUR 2.56 million (ph. I) EUR 3 million (phase II)	EUR 2.56 million (phase I) EUR 3 million (phase II)

* random sample

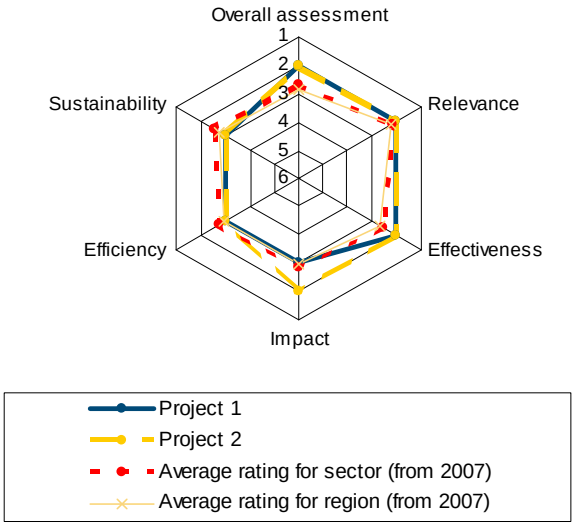
Short description: The programme comprised two phases and was implemented between 2003 and 2007. In the initial planning for programme phase I it was envisaged that as well as supplying contraceptives for family planning purposes, the programme would also provide condoms in order to help reduce the prevalence of HIV/AIDS. Due to the large-scale vertical financing of HIV/AIDS programmes by the Global Fund and other donors, however, the Government of Ethiopia requested KfW to instead (partially) cover gaps in funding for other family planning items. The items finally procured during phase I were 2.5 million doses of the injectable contraceptive Depo-Provera® (for administration in three-monthly injections) and 17,990 sets of the implant Jadelle®. In phase II 4.88 million cycles of oral contraceptives, 2.2 million three-monthly injections and 26,900 sets of the implant Jadelle® were procured. A consultant was also financed in order to support procurement and distribution of the contraceptives.

Objectives: The overall objective was to help improve the health of the population by reducing the birth rate and the rate of HIV infection. This was to be achieved by improving the supply of modern contraceptives (programme objective). The following programme objectives were also defined: improve the population's knowledge of modern family planning methods; improve the acceptance of modern family planning methods and their use within the population, and increase the rate of condom use for HIV/AIDS prevention. The indicators for the programme objectives were the prevalence rate for modern contraceptives (both phases) and the condom prevalence rate for HIV/AIDS prevention (phase I only). The indicator for the overall objective was the fertility rate (both phases). **Target group:** the entire sexually active population of reproductive age in Ethiopia, especially women aged between 15 and 49.

Overall rating: Note 2 (both phases)

Both phases of the programme were rated as overall good. This assessment is based on the good relevance, good results in the achievement of programme objectives, satisfactory efficiency (the latter being due to delays and a long implementation period), and sustainability.

Rating by DAC criteria



EVALUATION SUMMARY

Overall rating: both phases of the programme were rated as good **(2)**.

Relevance

Population growth in Ethiopia is high. While the country had a population of approximately 59 million in 1998, by 2011 this figure had risen to 82 million. Furthermore, at the end of the 1990s the fertility rate was high, i.e. 6.4 children per woman. Consequently, family planning services are highly relevant in Ethiopia, particularly since approximately 80% of the population live on less than two US dollars a day, and the maternal mortality rate in 2002 of approximately 850/100,000 was still comparatively high. The spread of HIV/AIDS has developed into an epidemic, affecting at least 1.5 million people in Ethiopia at programme appraisal for phase I. In recognition of this fact the Ethiopian Government decided to step up and expand family planning services and the control of infectious diseases, especially HIV/AIDS, and declared this to be among its priorities in the health sector – in cooperation with various governments, multilateral institutions and non-governmental organisations. Since May 2001, however, health has no longer been a priority area of German development cooperation with Ethiopia.

The availability of contraceptives is a key factor in implementing family planning services. In coordination with other donors such as UNFPA, USAID and DFID, and using financial contributions from the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM), the programme under evaluation was supposed to mitigate the shortage of contraceptives. According to the National Contraceptive Forecast 2004-2010, demand for contraceptives was forecast to grow at a rate of two percentage points per annum. Although the programme did not procure condoms, due to other vertical HIV/AIDS control interventions, the supply of oral contraceptives and three-month injections did cover a good third of the demand in 2005 (phase II). The programme also added on the further procurement of long-acting implants, which had already been introduced in phase I and in recent years have been promoted more strongly by the Ethiopian Government. Within the mix of methods the use of implants rose from 4% (DHS 2005) to 12% (DHS 2011).

The quantitative analysis performed as part of this ex post evaluation indicates that access to contraceptives is a significant obstacle to the use of contraceptives, particularly in rural areas, where some 85% of the population of Ethiopia live. Phase II of the programme focused more strongly on the rural population.

To summarise, both phases of the programme were justified and were of significant relevance in the overall context of governmental family planning activities. We rate phase I as being good overall. By contrast, the implementation of phase II was no longer part of a bilateral priority area. On the other hand, it included a stronger focus on particularly underserved rural areas. We therefore also rate phase II as good.

Sub-Rating: 2 (phases I and II).

Effectiveness

When phases I and II were appraised, the programme objectives were defined as follows:

- Improve the population's knowledge on modern family planning methods.
- Improve the population's acceptance of modern family planning methods.
- Increase the prevalence rate of modern family planning methods among the sexually active population.
- Improve the population's knowledge on ways to prevent HIV/AIDS.
- Increase the condom prevalence rate for HIV/AIDS prevention.

The indicators for achievement of the programme objectives upon completion of the programme were:

- The contraceptives procured through FC have been distributed to the end users.
- The contraceptive prevalence rate (CPR) rose from 7% (1997) to 12% in 2001 (phase I, target value was adjusted to take account of delays); the CPR for modern contraceptives rose from 10% (2003) to 14% in 2006 (phase II).
- The condom prevalence rate for HIV/AIDS prevention has risen (not quantified)

When phase II was appraised, the indicator for the programme objective "condom prevalence rate for HIV/AIDS prevention" was no longer included. We should also note that the target years defined at programme appraisal were revised, because the launch of both programme phases was delayed.

From today's perspective, the **programme** objective defined at the outset – deliver the contraceptives procured through FC to the end users – is to be seen as an output rather than an outcome, and therefore is not used here to evaluate the achievement of programme objectives. It will, however, be discussed in connection with the results achieved. The programme objective "increase the prevalence rate of modern family planning methods among the sexually active population" (also defined at appraisal) corresponds to the present state of the art. The corresponding indicator for this programme objective, which is identical to the programme objective itself, is a key indicator that reflects both the supply of and the demand for contraceptives. Along with the prevalence rate for modern contraceptives, the "level of unmet need for contraceptives" is also a suitable programme objective indicator. This has been added for the purposes of the present ex post evaluation.

Given the modification of the programme design, the programme objectives geared to behavioural change are no longer plausible. Similarly, we did not apply the programme objective indicator "condom prevalence rate for HIV/AIDS prevention" in the present ex post evaluation.

According to EDHS, the **CPR for modern contraceptives** improved countrywide from 6% in 2000 to 14% (2005), and again to 27% (2011) (EDHS). Although these EDHS baseline data are not identical to the data used in the programme appraisal (see above), they do indicate a very marked increase in the CPR. The target values defined at appraisal (for phase I 12% and 14% for phase II, countrywide average values) were also surpassed. If we disaggregate

the data by urban and rural regions, we see that in 2011 the CPR among married women in urban areas (52.5%) was significantly higher than the corresponding figure for rural areas (23.4%). Since 2005 the CPR in rural areas has more than doubled, whereas in cities it has grown by just under a quarter. However, it would appear that in rural areas of Ethiopia "knowledge barriers" (no knowledge of method of contraception or point of distribution) and "limited access" (distance from point of distribution, too expensive, impractical, preferred method not available) are still the main reasons for the non-use of contraceptives today. In urban centres a completed primary school education, gainful employment and rising incomes among women are factors conducive to the increasing use of contraceptives.

Among married women the **unmet need** for family planning is still 25% (national average, EHDS 2011). After 2000 (36%) it fell to 34% (2005) and subsequently significantly to 25% in 2011. The unmet need is defined as the percentage of women of reproductive age who wish to wait at least two years before they next give birth or are not planning to have any (more) children, and are currently not using any contraceptives. By this indicator too, we can therefore take it that the objective was achieved.

To summarise, we rate the effectiveness of phase I and phase II as good.

Sub-Rating: 2 (phases I and II).

Efficiency

Phase I of the programme provided for a term of 24 months (1999-2001). In connection with the Ethiopian-Eritrean border conflict, however, all activities of German development cooperation were suspended between May 1998 and June 2000. Further delays resulted from the change in general conditions (supply situation) and the renegotiation of the programme components. Phase I was completed with a delay of 23 months. It was also characterised by a pronounced fluctuation of staff at the Ministry of Health, and delays linked to the registration of the implant Jadelle. At programme appraisal for **phase II** a funding period of 18 months was agreed. However, actual implementation began only after a delay of 6 months. The planned implementation period was exceeded by approximately 15 months. Here too, the high fluctuation of staff within the programme executing agency affected the efficiency of the programme, e.g. by causing problems with the obtainment of specimen signatures to verify calls for disbursement. Political unrest (following elections in 2005) also impacted on the efficiency.

During both phases the contraceptive supply chain was based on the "push system". After the establishment of the Pharmaceutical Fund and Supply Agency in 2007 (not financed by FC), however, a switch was made to a pull system that involved detailed requests from health institutions regarding the supply of pharmaceuticals, including contraceptives.

It is not possible to produce a sound calculation of the total costs of couple-year protection (CYP), as there are no reliable data available on the costs of provision by the state. The **client costs** for CYP are as follows (as at the date of the ex post evaluation):

Contraceptives	USD/application	**Costs/CYP (USD)**	Remarks
Condoms	0.03 - 0.05	**3.6 - 6.0**	120 condoms per CYP
Oral contraceptives	0.1 - 0.5	**1.5 - 7.5**	15 cycles per CYP
Injectable contraceptives	0.6 - 1.25	**2.4 - 5.0**	4 injections per CYP
IUDs (spiral)	0.4	**0.09**	0.2174 IUDs per CYP
Implants including cannulae	8 - 16	**2.1 - 4.2**	0.263 implants per CYP

Both FC phases aimed to organise distribution via public health facilities and non-governmental organisations (approx. 15% of the contraceptives procured). Contraceptives are delivered to end users free of charge at public health facilities. With regard to the poverty situation, it is important to bear in mind that the proportion of the population in urban areas living below the poverty line (around 33%) is only slightly lower than the corresponding figure for rural areas (just under 40%). In urban zones, where more solvent clients also live, oral contraceptives and condoms are also marketed through a social marketing approach. Furthermore, condoms are sold at petrol stations and youth centres.

The official minimum wage in Ethiopia is around 5 USD per month. The costs of socially marketed products for one CYP are significantly less than 1% of this minimum wage (Chapman Index). The **end-user prices** for the products socially marketed by DKT are structured as follows (as at the date of the ex post evaluation):

Contraceptives	USD/application	**Costs/CYP (USD)**	Remarks
Condoms of the brand Sensation	0.03	**3.6**	120 condoms per CYP
Oral contraceptives of the brand Choice	0.1	**1.5**	15 cycles per CYP

The social marketing agency DKT (not financed through FC) works closely with the Ministry of Health. The commercial sector, e.g. condoms of the brand Durex, plays only a minor role; its market share as at the date of the ex post evaluation was around 2%. The information available does not allow us to conclude whether or to what extent the existing mix of modes for delivering contraceptives (social marketing, distribution free of charge and the private sector) is making exhaustive use of the existing potential in each case, i.e. whether or not we should assume that contraceptives are being over-subsidised. Regarding the mix of methods, the government is making efforts to promote long-acting contraceptives, though it faces a lack of knowledge/acceptance on the part of clients. To summarise, we rate the efficiency of phases I and II as satisfactory.

Sub-Rating: 3 (phases I and II).

Impact

For the purposes of the ex post evaluation, the **overall objective** of the programme was restricted to the contribution made to improving the health of the Ethiopian population of reproductive age. The additional goal of reducing HIV infections and AIDS-related illnesses defined at programme appraisal (both phases) was not included as part of the present evaluation, due to the change in design of both phases.

The **main indicator** for assessing the achievement of the overall objective was defined as the fertility rate, which fell from 5.9 (2000) to 5.4 (2005) and then to 4.8 children per woman in 2011 (according to DHS data). We should note that the fertility rate is not a direct indicator of health, but is rather a proxy indicator that reflects birth spacing as a key strategy for reducing population growth, and maternal and child mortality. In addition to the fertility rate, the ex post evaluation also applied the rate of maternal mortality and the rate of infant mortality as further indicators. Whereas infant mortality improved from 97/1,000 (2000) to 77/1,000 (2005) to 59/1,000 in 2011, a (further) improvement in maternal mortality has yet to be achieved: although it did fall from its baseline value of 871/100,000 for 2000, it stagnated between 2005 and 2011, on 673/100,000 respectively 676/100,00. Maternal mortality is without a doubt influenced by multiple factors, e.g. professional obstetrics and delivery at health facilities; these two factors come into play in just 10% of all births (DHS 2011). An important role is probably played here by the limited access to obstetrics in all areas (health centre, birth attendant). Moreover, the improved registration of maternal mortality during the period under evaluation may have had a negative effect on the statistics.

To summarise, we see a positive trend with regard to impact. It is plausible that the programme made a contribution to this. However, limited access to and poor awareness/knowledge of family planning methods remain a major obstacle to improving health, and continue to require efforts on the part of the government. We rate phase I as satisfactory. The stronger focus of phase II on rural areas probably led to greater impact: we rate phase II as good, phase I as satisfactory.

Sub-Rating: 3 (phase I), 2 (phase II).

Sustainability

Sub-Rating: Contraceptives are still being distributed to end users free of charge in public health facilities. In 2007 the government set up a modern logistics system, which was not a component of the programme and which has still to be fully implemented. A large number of distribution points and warehouses have already been implemented in this system, which is demand-driven. In the past, including the period during which phases I and II were being implemented, a system based on a push approach was used. It is envisaged that the current modern system will make a considerable contribution in the future toward guaranteeing the availability of contraceptives at public distribution points at all times, and thus toward sustainability. Notwithstanding this, limited access to contraceptives in rural areas remains a challenge, due to the distances between end users and their nearest health centre.

The procurement of contraceptives is still being maintained largely through external funding from other donors as well as the UNFPA Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS), whereas distribution is now being taken care of largely by the Ethiopian side. The behavioural changes brought about by improved access and increasing knowledge are leading to a continuous growth in demand for contraceptives. Therefore, funding by other donors and the government will need to be further increased in the future in order to achieve the desired increase in CPR. So far the financial contribution of the government to the procurement of contraceptives has been rather low (restricted largely to distribution), although budget lines at the federal and regional levels have now at least been created. External funding by international donors will also need to be continued in the future. It is believed that Ethiopia will also remain one of the largest recipients of UNFPA support for some years to come. Nevertheless, the widespread distribution free of charge and the high subsidisation of contraceptives supply do constitute a risk for sustainability.

Since the programme was appraised, the government programme does seem to have gained significantly in terms of sustainability, and donors now seem well organised. Regular consultations are taking place at both the financial and technical levels (Pharmaceutical Logistics Partners Meetings, Consortium of Reproductive Health Associations), and these are likely to have led to a coordinated implementation of family planning activities. To summarise, we rate the sustainability of both phases as satisfactory.

Sub-Rating: 3 (phases I and II).

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

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

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

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

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

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

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

Sustainability level 3 (satisfactory sustainability): The developmental efficacy of the project (positive to date) is very likely to decline significantly but remain positive overall. This rating is also assigned if the sustainability of a project is considered inadequate up to the time of the ex post evaluation but is very likely to evolve positively so that the project will ultimately achieve positive developmental efficacy.
Sustainability level 4 (inadequate sustainability): The developmental efficacy of the project is inadequate up to the time of the ex post evaluation and is very unlikely to improve. This rating is also assigned if the sustainability that has been positively evaluated to date is very likely to deteriorate severely and no longer meet the level 3 criteria.

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