Namibia: Family Planning / HIV Prevention I and II

Ex post evaluation report (final review)

OECD purpose code	13030 and 13040 / Population policies /reproductive health	
BMZ project number	Phase I: 1996 65 894, Phase II: 2001 66 108	
Programme executing agency	National Social Marketing Programme	
Consultant	GITEC	
Year of ex post evaluation report	**2008**	
	Programme appraisal (planned)	**Ex post evaluation report (actual)**
Implementation commenced	I) 3rd quarter 1997 II) 2nd quarter 2003	I) 4th quarter 1999 II) 3rd quarter 2003
Implementation period	I) 54 months II) 36 months	I) 39 months II) 36 months
Investment costs	I) EUR 3.9 million II) EUR 2.6 million	I) EUR 3.9 million II) EUR 3.1 million
Counterpart contribution	I) EUR 1.1 million II) ./.	I) EUR 1.1 million II) ./.
Financing, of which FC funds	I) EUR 2.8 million II) EUR 2.6 million	I) EUR 2.8 million II) EUR 3.1 million
Other institutions/donors involved		The Global Fund to Fight AIDS, Tuberculosis and Malaria
	Family Planning / HIV Prevention I	Family Planning / HIV Prevention II
Overall rating	3	3
• Relevance	2	2
• Effectiveness	2	2
• Efficiency	3	3
• Impact	2	2
• Sustainability	3	3

Brief description, overall objective and project objectives with indicators

Both programmes are based on the social marketing approach. As well as the distribution of subsidised condoms using private-sector marketing methods, this approach also includes information, education and communication work with the sexually active population concerning

HIV/AIDS, sexually transmitted diseases (STDs), family planning (FP) and the correct use of condoms. The two programmes share the same programme objective: improve the supply of high-quality but low-cost condoms and other contraceptives, inform and educate the population, and supply essential drugs. The overall objective was to help reduce the increase in HIV/STD prevalence, and improve options for family planning based on personal choice. The indicators for the achievement of the programme objective were the number of condoms sold within a certain period of time. The indicator applied in order to ex post assess for the achievement of the overall objective was a reduction in HIV prevalence. Furthermore, to measure the results of the programmes an analysis was conducted of the changes in behaviour (regarding the use of condoms) which the social marketing approach aimed to bring about.

Since the programme appraisals conducted in 1996 and 2001, the spread of HIV/AIDS has remained one of the central challenges faced by the Namibian health system. The HIV/AIDS prevalence rate rose particularly rapidly between 1992 and 1996, climbing from 4.2% to 15.4%, before peaking in 2002 at 22.3%. Fortunately, the assumption made in the appraisal report of 19 December 2001, i.e. that the prevalence rate would rise further to 25% by 2005, proved false. The most recent study – the National HIV ANC Sentinel Survey 2006 – specifies an average HIV prevalence rate of 19.9 %. In some regions the average prevalence rate is already almost 40% (Katima Mulilo – 39.4%). The studies to determine the HIV prevalence rate are carried out by the Namibian Ministry of Health and Social Services (MoHSS) every two years. These studies relate to the sexually active population, including pregnant women who attend clinics and are tested for HIV. Namibia is now the country with the fifth-highest number of people living with HIV in the world.

Design of the programme

The target group of the programmes was the sexually active population of Namibia. At appraisal no further restriction was placed on the target group, given the low size of population (around 1.9 million at programme appraisal). One special focus was on the information and education campaigns for the key social groups (youth, unmarried women and men), who have more difficulty in gaining access to services provided by the public health system. Moreover, the group of young people (defined in Namibia as the group aged between 15 and 30) display the highest rate of growth in the number of HIV/AIDS cases, and were therefore assigned priority in HIV/AIDS prevention programmes. Because of the special sensitivity of this issue, many young people find the idea of visiting public health facilities in order to obtain contraceptives inconceivable.

Overall responsibility for both programmes was assigned to the Ministry of Health and Social Services (MoHSS), Directorate for Policy, Planning and Human Resources Development, which works closely with the National AIDS Control Programme and the Family and Community Health Division (the latter is responsible for reproductive health). Largely autonomous responsibility for implementation was assigned to the National Social Marketing Programme (NaSoMa). When the permanent presence of an international long-term consultant came to an end as planned in early 2002, management of NaSoMa was taken over by a highly motivated local director who in our opinion was already sufficiently well qualified. She was later succeeded by another local director.

The storage and distribution of the condoms was performed using the established logistics system of NaSoMa. The condoms supplied were first of all stored in the warehouse in Windhoek, from where they were distributed to the regions. At the end of phase I, 5 teams were serving approximately 320 points of sale in 13 districts, most of which were small shops, dispensaries, drug stores, petrol stations and bars. During phase II the distribution network was expanded considerably (according to the final review report of 07 November 2007, it then included over 2,000 points of sale). The FC programmes were extended countrywide by opening regional offices in Rundu, Oshakati, Otjiwarongo, Keetmanshoop and Katima Mulilo. This provided economically weak rural regions with improved access to the condoms financed through FC.

In terms of improving the supply of high-quality, low-cost condoms through a social marketing approach, the programme design proved appropriate and adequate. Phase II focused on developing a strategy for behaviour-changing measures – the Behaviour Change Campaign

(BCC). Through advertising measures (newspaper ads, radio and TV spots), numerous information and education measures (participation in trade fairs, video shows, radio talk shows, presentations in bars, youth clubs etc.) and special events for high-risk groups (prostitutes, mobile labourers, youth), some 200,000 people were reached. Workplace programmes in various companies reached some 4,500 workers. NaSoMa currently lacks a detailed evaluation of the BCC measures carried out to date that would enable it to make qualitative improvements, particularly in the workplace programmes (phase III).

Key findings of the results analysis and rating

The programme objectives were basically achieved. In the course of the Family Planning / HIV Prevention I programme, 5.2 million condoms were sold within 3 years. This met the target originally formulated when the programme was appraised. In the course of the Family Planning / HIV Prevention II programme, 13.2 million condoms were sold – 8.7 million more than originally planned.

Concerning the achievement of the overall objective (reduction in HIV prevalence), a certain stabilisation was achieved. Following an increase in the HIV prevalence rate from 15.4% in 1996 to 22.3% in 2002, the figure was then stabilised at 19.7% / 19.9% in the period 2004 - 2006. Bearing in mind the existing risks for an undiminished increase in the prevalence rate, this stabilisation can be seen as a positive result. Nevertheless, despite the numerous measures in the fight against HIV/AIDS the HIV prevalence rate in Namibia remains alarmingly high. Therefore, in view of the scale of the epidemic and the difficult sociocultural conditions, barely any visible success in reducing HIV prevalence is to be expected, even in the medium term.

The end user price for the various condom brands varies, depending on the brand and income bracket, between 0.5%, 1%, 4% and 6% of available household income for one couple-year of protection (CYP) (120 condoms). Overall, the level at which sale prices were set is appropriate for maximising the distribution of condoms, given the low incomes of large sections of the population. One exception is a female condom, which is sold at a price that is not appropriate for rural incomes.

In the Family Planning / HIV Prevention I programme, the average costs for one CYP – taking into account procurement and marketing costs – were EUR 65. In the Family Planning / HIV Prevention II programme, these costs were almost halved to EUR 34.5 per CYP.

It is chiefly women whose lives are made easier by condom-based HIV prevention, as they bear the main burden of looking after and caring for family members with AIDS. Furthermore, the targeted information and education work on HIV/AIDS, and especially on the use of female condoms, have enabled young women and female prostitutes to reduce the risk of infection. They have also been strengthened in articulating and asserting their own interests (especially toward men).

Heavy subsidisation means that the condoms are sold at affordable prices. This provides the poor population in particular with easier access to HIV prevention. The supply of contraceptives to the poor population is also improved by including points of sale in small rural locations.

No significant environmental burdens are to be expected. The programmes were not oriented toward “participation/good governance”. However, we do see the approval and establishment of social marketing agencies for HIV/AIDS control as a meaningful contribution toward good governance.

To summarise, we rate the aid effectiveness of the project as follows:

Relevance: The project is justified because it addresses a sector that remain relevant to this day: HIV/AIDS remains a development-policy priority for Namibia. Given the very high prevalence rate of HIV/AIDS, and the high economic costs which this entails, the FC project addressed a central and persistent constraint to economic and social development in Namibia. The chain of results assumed in the programme appraisal reports, according to which the supply and sale of subsidised contraceptives would make a contribution toward HIV/AIDS control and thus improve the health situation, remains valid today. Cooperation between the various donors engaged in this area is positive. The social marketing programme established through FC has become a permanent component of the national strategy for AIDS control. The

programmes were closely aligned with Namibia's development-policy priorities and the goals of German development policy. We rate the overall relevance of both phases as good (2).

Effectiveness: The programme objectives were designed to achieve two things. The first objective was to improve the supply of high-quality but low-cost condoms to the population of Namibia. The second was to improve the Namibian population's knowledge and awareness of HIV/AIDS, STDs, family planning and the correct use of condoms. The indicators defined for the achievement of objectives were the condom sales figures. The programmes achieved the defined marketing targets, and in some cases surpassed them by a significant margin. According to the KAP (Knowledge, Attitudes & Practice) studies carried out, the proportion of frequent condom users was increased from 49% to 90%, and respondents were found to possess good knowledge of HIV infection. Their knowledge of STDs remained at a low level (10%), however. We rate the overall effectiveness of both phases as good (2).

Efficiency: The key parameters for measuring efficiency in social marketing programmes include the costs for one CYP. The sales price differentials in Namibia are in line with international standards. The goal of ensuring that the costs to households for one CYP should not exceed 1% of their income was achieved consistently, with the exception of the female condoms. However, female condoms account for only a small proportion of the totality of condoms marketed. Taking into account the procurement and marketing costs, the costs of around EUR 65 for one CYP in phase I and around EUR 34 in phase II are comparatively high. Nevertheless we believe that these costs are warranted, first of all because of the specific general conditions in Namibia (low population density, costly distribution structure), and secondly because of the programme is delivering needed start-up funding for HIV/AIDS prevention. It is virtually impossible to quantify allocative efficiency, as data on savings made in terms of health care, commercial and administrative costs cannot be ascertained. We rate the overall efficiency of both phase as satisfactory (3).

Impact: At the appraisals, the overall objective of the FC programme was defined as being to reduce the increase in the rate of new HIV and STD infections / reduce infection rates, and to improve options for family planning based on personal freedom of choice. Given the complex chains of cause and effect, indicators were not assigned. Since it was extremely difficult to forecast the long-term effects of HIV/AIDS on population size, the original objective of phase I – to reduce the birth rate – was disregarded. Since the MoHSS did not approve implementation of the "morning after pill" component, the family-planning component (objective of phase II) was not pursued further. The overall objective of reducing the rise in HIV prevalence was not achieved. What was achieved was a stabilisation. By contrast, what was especially positive were the structural results of the programme. Being the first national initiative for HIV prevention, these programmes had to overcome very major obstacles in a socially conservative environment. Ultimately the programme made a key contribution toward lifting the social taboo on the topic of HIV/AIDS and prevention through condom use. The FC programme made a direct contribution toward achieving MDG 6 (combat HIV/AIDS). By preventing infections, it also helped improve maternal health (MDG 5) and reduce child mortality (MDG 4). Primarily because of the structural impact, we rate the impact of the two phases as good (2).

Sustainability: A major risk in social marketing programme is ensuring sustainability. Despite the measures taken, such as restructuring NaSoMa so that it became a legally independent organisation (a non-profit company), and designing an exit strategy as part of the FC programme Family Planning/HIV Prevention III, the sustainability of the executing agency structure involves major risks. The sales revenues generated are far from sufficient to cover the running costs and finance the further procurement of contraceptives. However, we should not expect sustainability in the sense of complete independence from external funding. The unfavourable general conditions, especially the distribution of condoms free of charge by the Ministry of Health, are compounding this risk. The NaSoMa will remain dependent on external funding in the long term. The Family Planning/HIV Prevention III programme currently being implemented may help further reduce the risks that still exist, and identify further options for a reliable and long-term availability of further external support. We rate the sustainability of both phases as satisfactory (3).

On the basis of the criteria listed above, we rate the aid effectiveness of both phases as satisfactory (3).

Conclusions for all the programmes

- To further mainstream the social marketing approach and ensure its sustainability, one option would be to include hospitals, health posts, doctors, birth attendants and private laboratories in the target group. This would boost the structural impact of social marketing significantly.
- One of the central challenges of social marketing programmes is the dependency of social marketing agencies on external funding for ensuring the sustainability of their IEC work and distribution of subsidised contraceptives. All too often, external funding is of limited duration. Therefore, projects should be designed from the outset to include income generation by the social marketing agencies themselves. In other words, the social marketing agencies should create the material basis for their own financial independence (e.g. by renting out their own buildings, pursuing commercial activities of their own or organising training courses for doctors).

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 (outcome), impact and efficiency. 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 rating that clearly exceeds expectations

2 Good rating fully in line with expectations and without any significant shortcomings

3 Satisfactory rating – project falls short of expectations but the positive results dominate

4 Unsatisfactory rating – significantly below expectations, with negative results dominating despite discernible positive results

5 Clearly inadequate rating – despite some positive partial results the negative results clearly dominate

6 The project has no positive results or the situation has actually deteriorated

A rating of 1 to 3 denotes a positive assessment and indicates a successful project while a rating of 4 to 6 denotes a negative assessment and indicates a project which has no sufficiently positive results.

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. A rating of 1 to 3 indicates a "successful" project while a rating of 4 to 6 indicates an "unsuccessful" project. It should be noted that a project can generally only be considered developmentally "successful" if the achievement of the project objective ("effectiveness"), the impact on the overall objective level (impact) and the sustainability are considered at least "satisfactory" (rating 3).