KFW

Ex Post-Evaluation Brief

NIGER: Social Marketing for HIV Prevention (Phases I and II)

Sector	13040	
Programme/Client	Soziales Marketing zur HIV Prävention (Phase I, BMZ Nr. 2000 66 763)* und Reproduktive Gesundheit einschl. HIV-Prävention (Phase II, BMZ-Nr. 2005 65 960)**	
Programme executing agency	Coordination Intersectorielle de la Lutte contre le Sida - CISLS	
Year of sample/ex post evaluation report: 2012, 2013/2013		
	Appraisal (planned)	Ex post-evaluation (actual)
Investment costs (total)	(I) 5,36 Mio. EUR (II) 3,21 Mio. EUR	(I) 5,39 Mio. EUR (II) 3,22 Mio. EUR
Counterpart contribution (company)	(I) 0,25 Mio. EUR (II) 0,21 Mio. EUR	(I) 0,28 Mio. EUR (II) 0,22 Mio. EUR
Funding, of which budget funds (BMZ)	(I) 5,11/5,11 Mio. EUR (II) 3,00/3,00 Mio. EUR	(I) 5,11/5,11 Mio. EUR (II) 3,00/3,00 Mio. EUR

* Projects in random samples 2012; ** Projects in random samples 2013

Short description: Phases I and II of the HIV prevention programme were implemented between 2003 and 2010 and support the national HIV/AIDS programme to avoid an HIV/AIDS epidemic. Phase I included developing a national social marketing agency, which pursued the development, distribution and marketing of a high-quality and affordable condom brand, as well as developing educational materials and organising information events. These activities were expanded and extended to new regions in Phase II. While condom distribution was organised in a nationwide distribution structure, the social marketing activities for behavioural change were limited to the city of Niamey, as well as the rural regions of Maradi and Tahoua (city and selected villages) during the first two phases.

Objectives: The programme objective of both phases was to promote the increased use of condoms by means of the development of sustainable distribution systems in the private sector, as well as measures for behavioural change. This was to contribute to the stabilisation of the HIV infection rate and other sexually transmitted diseases (STDs), as well as to avoid unwanted pregnancies (primary goal).

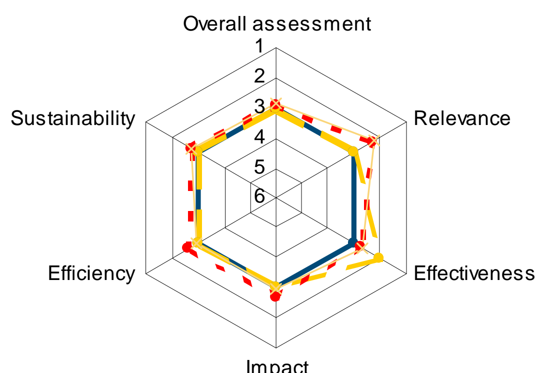
Target group: The sexually active (15 to 49-year-old) Nigerien population affected by poverty with a special focus on the HIV/AIDS risk groups (sex workers, mobile populations, the military and young people) in the programme region.

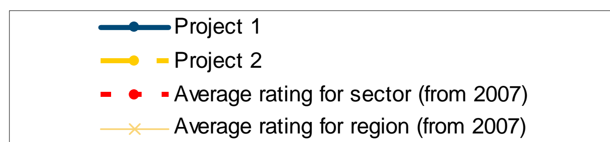
Overall rating: 3 (Phase I and II)

Points to note:

- Establishment of an effective social marketing concept directed at a target group living in both rural and urban environments
- High level of commitment on the part of political authorities and organisations
- KAP studies prove that the topics of HIV/AIDS and STDs have undergone both social and political liberalisation, despite massive religious resistance at the outset.

Rating by DAC criteria





EVALUATION SUMMARY

Overall rating: Phases I and II have reached their goals. Condom use was increased and one can reasonably assume a positive effect on the HIV and STD infection rate. We, therefore, assess both phases as satisfactory.

Rating: 3 (Phases I + II)

Relevance

The review of programme Phase I took place on the assumption of an estimated HIV prevalence rate of approx. 2%[1] in the population as a whole and up to 35% in risk groups (sex workers, long-haul truck drivers and migrant workers), as well as a higher rate of HIV prevalence existing in the neighbouring countries of West Africa[2]. When Phase I was reviewed, the lack of knowledge regarding sexually transmitted diseases including HIV/AIDS and the practically non-existent supply of condoms in an easily accessible private sector were identified as the core problems. Furthermore, an unfavourable socio-cultural climate prevailed in Niger, based on a negative attitude on the part of religious leaders with regard to the use and public distribution of condoms. The political significance had improved with the rising political awareness of the existing threat from HIV/AIDS, confirmed above all in the foundation of the inter-sector co-ordination centre CISLS and the presentation of the first national strategy paper "Cadre Stratégique National de Lutte contre les IST/VIH/SIDA, 2002-2008". Another development hurdle, the extremely high population growth (2.67% in 2000) or very low prevalence rate of contraception (4.6% in 1992) was taken up as a development policy goal, but this goal was barely addressed in the measures.

The programme concept or chain of effects assumed that better education of the sexually active population regarding the prevention and transmission of HIV infection and other sexually transmitted diseases would lead to a higher acceptance of condoms. The aim was to bring about changes in sexual practices in connection with better access to condoms, in turn contributing to a reduction in new HIV/STD infections. These causal relationships in Phases I and II are still correct and constructive today. The causal relationship also assumed that condoms are also used to extend the interval between births and/or prevent unwanted pregnancies. This is the case only depending on the acceptance of the user.

The foundation of the social marketing agency ANIMAS-SUTURA as an independent non-government organisation, the establishment of a condom brand accepted by the population that integrates well-known personalities and religious leaders, as well as the use of existing distribution and sales formats in the private sector are just as essential to success and the effects of the programme as the educational work directed at the various primary target groups, which placed protection against STD/HIV/AIDS in the broader context of family planning and reproductive health. Health is not emphasised in German co-operation with

[1] UNFPA 1998

[2] Chad 3.2% and Nigeria 3.8% in 2001, UNAIDS Report on the Global AIDS Epidemic, 2010

Niger today; nevertheless, the programme provides for long-term support of the sector with the financing of the follow-up Phases III to VI. The topic of family planning and the introduction of hormonal contraceptives (the pill) to support family planning in Niger, tested in Phase II, were implemented in the follow-up phases. We assess the relevance of Phase I and Phase II as satisfactory.

Sub-Rating: 3 (Phases I + II)

Effectiveness:

In the programme review of Phase I "*an improved supply of affordable and high-quality condoms*" via "*the development of sustainable distribution systems in the private sector"* was defined as programme objective and the review of Phase II (including inventory checks) developed to the extent that the "*increasing use of contraceptives*" [3], which primarily referred to the inventory check at the time, however, was in the forefront. Since the inventory check was not part of Phase II and no other contraceptives were sold other than condoms, the relevant programme objective for Phases I and II for the ex post evaluation is: "*Increasing use of condoms by developing sustainable distribution systems in the private sector*". In Phase I, indicators were only defined at the performance level so that state-of-the-art indicators from Phase II were used to evaluate the goal achievement of the programme. The three indicators are thus worded:

(1) Increase in the number of individuals who state that they have used a condom during their most recent sexual encounter;

(2) Increase in the number of individuals who state that they wish to avoid unwanted pregnancies or extend the interval between births with condom use;

(3) Increase in the number of individuals from the rural area who can name a specific point of purchase or sales centre for condoms.

Starting and target values were not available at the time of the review of Phase I and should be determined as part of the KAP (knowledge, attitude, practice) studies to be conducted. The first KAP study, however, did not take place until 2007. Given the thus limited data availability for Phase I the originally defined "Number of condoms sold" and "Share of cost coverage from sales proceeds" were included in the assessment.

The KAP studies conducted in 2007 and 2010 showed general improvement in various knowledge and behavioural indicators with respect to STD/HIV/AIDS. The development of target indicators (1), (2) and (3) was as follows. The comparison between 2007 and 2010 shows that significantly more respondents had developed a positive attitude to the use of condoms (1) in 2010 than in 2007, especially in the case of sex with different partners. It is

[3] The review of the second phase included the inventory check for the introduction of the pill, which, however, only took place during the third phase. The programme objective, therefore, should include all contraceptives, both pills and condoms. Condoms play a very minor role here, however.

noteworthy that the percentage rise for men using condoms in extramarital contact is approx. 11 percentage points (from 42% to 53%). The results regarding the use of condoms as a family planning method (2) showed increased knowledge regarding the possible two-fold function of condoms. 58% of users of condoms in villages with social marketing activities indicated that they wanted to protect themselves not only against HIV, but against unwanted pregnancy. Even in the comparison group (villages without social marketing activities) this figure was approx. 40%. During the ex post evaluation it was confirmed in personal interviews with sex workers that condoms were used as an effective method for protection against pregnancy and that the use of hormonal contraceptives was dispensed with completely. With regard to knowledge indicator (3) regarding the nearest point of sale for condoms, approx. 10% of women could provide specific information in 2007 and 30% of men. In 2010 this figure was approx. 33% for women and 45% for men, with the knowledge in villages with social marketing activities significantly higher at up to 58%. During the second programme phase it is estimated that 8.6 million people were reached via radio campaigns and television spots.

16.6 million condoms were sold in Phase I. This figure is considerably below the original goal of 20 million condoms. This result is in large part due to general start-up difficulties, problems when introducing the social marketing condom brand (change in concept), as well as changes in the distribution network from direct selling to a private operating basis.

Despite the restricted data basis during the review of Phase I, as well as limited comparability of the data collected after the conclusion of Phase II, one can assume that clearly positive developments have taken place for all three indicators. We therefore assess the effectiveness of the programme in Phase I as still satisfactory and Phase II as good.

Sub-Rating: 3 (Phase I), 2 (Phase II)

Efficiency

Programme Phase I was extended from 60 to 63 months to use the remaining funds (March 2002 to May 2008). This created a continuous transition to Phase II, which lasted 33 months (June 2008 to March 2010) (Phases I and II totalled 7 years). The originally stated sales figures from Phase I were reduced during the course of the programme in 2004 due to the more time-consuming launch of the new condom brand Foula. A sales target figure of approx. 15.5 million condoms was specified for the programme duration of Phase I. This goal was largely met by 16.6 million condoms sold (including 5% samples). The target figure of Phase II amounted to 8.85 million condoms, with 8.5 million condoms sold until the end of the second phase. As a result, despite the difficult cultural context of the seven-year term (Phases I and II) 209,197 Couple Years of Protection (CYP[4]) were deducted. Annual condom sales were able to be increased by approx. 14%. Programme costs per couple years of protection are approx. EUR 37 per CYP for Phase I and EUR 44 per CYP for Phase II. In the

[4] Couple Year of Protection: According to the definition by UNAIDS, a factor of 120 condoms per couple year of protection for condoms. (http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/cyp)

case of comparable programmes in the region with similar structural and socio-cultural conditions, equally high costs/couple protection year were calculated (Chad: EUR 39/CYP[5]). They are, however, twice as high as the regional average. In this case the cost-intensive development time of the social marketing agency (see Sustainability) founded in 2007 and the significant additional cost for social marketing activities in increasingly thinly settled agricultural areas (Phase II) become noticeable. In addition, the sales figures, but not the fulfilment of demand, were at times negatively influenced by the unco-ordinated supply of free condoms by the government of Niger under the GFATM programme[6]. If one looks only at the expenses of the agency for packaging, quality control, logistics and distribution, they were under the direct operating costs / couple year protection for Phase II at c.5 EUR/CYP and increase in procurement costs for condoms at c. EUR 6.40/CYP. If one takes into account the personnel costs and ongoing costs of teh agency, costs of EUR 16/CYP result. This reflects implementation costs of c. EUR 0.13/condom, which were set in the review of Phase I at EUR 0.08 per condom. Condoms had to be subsidized to a higher degree than originally provided for due to the generally low income situation of the target group.

The distribution structure in the meantime uses the most far-reaching existing structures of commercial wholesalers and vendors who assume responsibility for distribution in all parts of the country. By now 48 wholesalers and 607 distributors belong to the ANIMAS distribution network supplying approx. 11,620 points of sale in the country. To improve sales in Niamey, ANIMAS salespeople were trained in the course of Phase II who support the development of points of sale in Niamey with educational work. The initially purely sales-driven system (pull) is thus supported by sales-promotion measures which generate costs (push). The project can only fulfil efficiency requirements to a certain extent based on a purely financial perspective. Difficult socio-economic framework conditions and the more costly distribution and communication system in rural areas in Niger, as well as the monitoring of expenses for the creation of social marketing activities and supporting material directed to the relevant target group can be positively attributed to the efficiency of the programme. In particular, however, against the backdrop of the social liberalisation process achieved, we assess the efficiency of both phases as barely satisfactory.

Sub-Rating: 3 (Phases I and II)

Impact

The primary goal for programme Phases I and II was defined as a contribution to the stabilisation of the HIV infection rate and the infection rate of other sexually transmitted diseases (STDs), as well as the avoidance of unwanted pregnancies/extension of intervals between births. There is no data on the incidence of HIV/AIDS. Instead, HIV prevalence is used to assess development. There are neither incidence nor prevalence figures for STD goals. The fertility rate was used for the goal of fertility.

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[5] KfW ex post evaluation report Chad: Family Planning and HIV Prevention IV, 2012

[6] A total of 7.6 million condoms was procured between 7/2008 and 3/2010 according to the GFATM report.

HIV prevalence was established at 0.7% for 15 to 49-year-old inhabitants of Niger in the course of the EDSN=MICS III 2006. This is indeed lower than the estimated figure of approx. 2% at the time of the review of Phase I, but a reliable statement on development will only be possible after the still pending publication of EDSN IV conducted in 2011/2012. Various measurements show HIV prevalence at between 1.0% and 2.7% for most risk groups, with the exception of professional sex workers at approx. 35% in 2009[7] with wide regional differences. Significantly higher figures were also measured in the southern areas of Maradi (approx. 61%), Tahoua and Zinder (approx. 42% - 43%). Due to the lack of informative studies it cannot be determined what contribution the project had and still has on the development of HIV prevention using behavioural changes and promoting the use of condoms as compared to preventive drugs and the life-extending effects of antiretroviral therapies (ART). It is reasonable to assume, however, that the project has led to a drop in new infections due to improved access to affordable condoms and above all educational campaigns also in remote rural regions. The removal of social taboos against STD/HIV/AIDS has freed the way to active government intervention. In the meantime, for instance, social marketing programmes are being conducted with international donors (UNFPA, World Bank, etc.) and government authorities, which are also in line with the programme goal, for additional regions and government institutions (schools, military training, etc.). The treatment of HIV patients has also been steadily improved and according to UNAIDS was estimated at 28%[8] in 2011.

A positive contribution due to the proven increased use of condoms and improved education can be assumed with regard to the spread of STDs; direct quantification is, however, not possible in this case either given the available data. Fertility on the other hand hovered almost unchanged at the highest level in the world of 7.16 live births per woman since PP.

Overall, it is plausible to assume that the programme has contributed to HIV/AIDS and STD prevention, but that it has been less effective than expected due to the difficult initial socio-economic situation (primarily Phase I) and accessibility to the target group living in the rural area (primarily Phase II). The contribution to the topic of avoiding unwanted pregnancies cannot be properly determined. The social liberalisation with respect to the topics of HIV/AIDS and family planning (Phase II) can be assessed as positive on the whole. Against this background we assess the overall effectiveness of both phases as satisfactory.

Sub-Rating: 3 (Phases I and II)

Sustainability

The sustainability of Phases I and II can be determined only in limited fashion on the basis of current operating costs, but should also address the longer-term direction of the programme. Lower coverage of total costs during Phase II (7% versus 10% in Phase I) is due to higher

[7] National report UNGASS 2010 - Sentinel surveillance 2009
[8] In 2010 c. 28% of individuals infected with HIV who needed antiretroviral therapy (c.27,000) were treated. GFATM Grand Performance Rapport Niger, Update Oct. 2012.

operations management costs from taking on additional tasks (hiring additional financiers, development of an in-house communications department and preparation of the launch of the pill for the follow-up phase) which are, however, relevant to sustainability. The development of a functional and effective distribution system as well as an internal production centre for audio and video campaigns is the reason why the social marketing agency sees this as a reference for certain health products in Niger. The alternative to developing an in-house production centre might have been to commission one externally, but ANIMAS SATURA has a very good reputation in this domain. As a result, the agency was able to attract another major financier besides the German FC (distribution and marketing of water purification tablets) for the first time in 2010. The agency, now recognized as an NGO in Niger, has the necessary internal structure, a Supervisory Board and extensive cost transparency, which should ensure efficient operations. The internal business plan for the years 2012-2016 assumes that additional financial resources in the amount of up to 33% of the total budget for family planning and HIV/AIDS will be attracted. This additional financing supports the programme objective and a certain sustainability of the agency, provided, as is planned according to our information, care is taken regarding strict cost coverage of the expenses arising from additional orders.

Existing potential for cost reductions has, however, not been exhausted (e.g. price of condom and profit margin in the distribution chain). Despite a high level of willingness on the part of the government of Niger to support the programme, due to the difficult budget situation it is currently not possible for it to be funded from national resources in the event of the elimination of German financing. The attraction of international financiers (World Bank, GFATM, etc.) has not been sufficient to date for sustainable operation of the overall programmes. At the same time, the subsidy share for condoms is still relatively high and is currently considered over-subsidized due to the low market price that has been in place for 10 years.

A certain sustainability can be pointed out with regard to effects, even if they cannot be looked at on an isolated basis in a programme that continues to be conducted. Changing risky behaviour, e.g. by means of additional condom use and changes in socio-cultural attitudes, as well as attracting the support of religious and recognised leaders is a tedious job that progresses only slowly in Niger due to the socio-economic and cultural environment. KAP studies prove that the topics of HIV/AIDS and STDs have undergone both social and political liberalisation, despite massive religious resistance at the outset. This cannot be easily reversed, but still needs constant commitment in terms of educational work. On the whole, therefore, we assess Phase I as barely satisfactory and Phase II 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).