Ex post evaluation – Tanzania

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Sector: Health, family planning, HIV/AIDS (CRS Code 13040)
Project: Co-financing the social marketing of condoms and contraceptives, BMZ No. 2005 65 796*
Programme-/Project executing agency: Ministry of Health/Social Marketing Agency

Ex post evaluation report: 2014

		Project A (Planned)	Project A (Actual)
Investment costs (total)	EUR million	27.90	28.63
Own contribution	EUR million	2.50	28.63
Co-financing of other donors	EUR million	17.40	0.68
Funding	EUR million	8.00	19.95
of which BMZ budget funds	EUR million	8.00	8.00

*) Random sample 2014

Description: The plan was to continue developing the social marketing project on HIV/AIDS prevention and family planning, as operated by the social marketing agency since 1993. Under a co-financing framework with the Royal Netherlands Embassy (RNE) and using funds from the Global Fund, the social marketing activities were to be expanded in particular to other rural regions through the FC financial contribution. New brands of modern contraceptives were to be developed and put on the market to mitigate the chronic under-supply of the sexually active population by providing inexpensive private-sector products. Further measures concerned the implementation of knowledge, attitude and practical studies, advertising campaigns and improving the knowledge, attitudes and behaviour of the population.

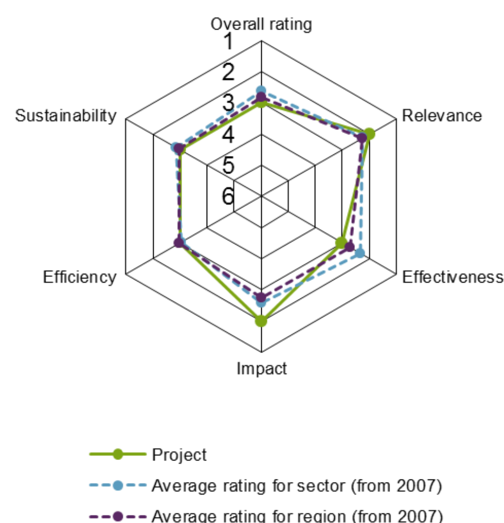
Objectives: By improving the supply of condoms and contraceptives as well as implementing communication measures, the target group was to be better informed about HIV/AIDS, other sexually transmitted diseases, unwanted pregnancies and their prevention, enabling them to protect themselves more effectively against HIV/AIDS, sexually transmitted diseases and unwanted pregnancies (project objective). This was designed to help lower the HIV prevalence rate and reduce the number of unwanted pregnancies (overall objective).

Target group: The sexually active population and population affected by poverty in Tanzania. The project was specifically aimed at groups at risk of HIV as well as young people aged 15-24. With all of the measures, special emphasis was placed on reaching out to women.

Overall rating: 3

Rationale: High relevance, the satisfactory achievement of the project objectives and the overall developmental impact led to a satisfactory rating on the whole, despite the somewhat weaker efficiency.

Highlights: In spite of significant efforts from both the state and donors as regards family planning since the beginning of the 1990s, and the free supply of contraceptives, no radical reduction was achieved in the high birth rate. This underlines the cultural and religious factors and raises the question of how to address the topic properly. The combination of public health services and social marketing as launched in subsequent phases in the field of family planning, particularly in remote rural regions, seems to be a very promising approach against this backdrop, and proves the innovation of the project-executing agency.



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Rating according to DAC criteria

Overall rating: 3

The project was highly relevant and has contributed positively to the developmental impacts. The results of the project's effectiveness, efficiency and sustainability are satisfactory. All told, the sub-ratings for the sexual and reproductive health components are not as positive as those for the HIV/AIDS prevention component, and so the project's overall rating is satisfactory (3).

Relevance

The project objective was consistent with the priorities of the partner government and the Tanzanian family planning policy. It was oriented strongly towards the "National Multi-Sectoral Strategic Framework for HIV/AIDS" (NMSF) and the national poverty reduction strategy, which is today regarded as one of the priority areas of Tanzanian healthcare policy. Additionally the project approach complies with international development policy priorities, especially MDG 6 (combat HIV/AIDS, malaria and other diseases), MDG 5 (improve maternal health), and MDG 3 (promote gender equality and empower women).

The underlying results chain for the project is largely plausible. The target group for the generic educational work was the country's sexually active population. The marketing measures were especially aimed at young people and groups at high risk of HIV, with a particular focus on reaching women. What is more, project measures were tailored specifically for the poor population. Due to the national prevalence of HIV/AIDS and the very high national fertility rate (both exhibiting tremendous regional differences), the project measures and the regional and zonal deployment of the project-executing agency are very relevant. At 6.1 children/woman the fertility rate is distinctly higher in rural regions than in cities, where the rate is 3.7 children/woman; however, HIV prevalence is higher in cities than in rural areas (7.2 % vs. 4.3 %, though the absolute number of people carrying the virus in rural regions is higher). From today's perspective, this was not sufficiently taken into account when designing the project. The social marketing (SM) approach is therefore limited in areas with a low population density, where educational campaigns are particularly costly and only few formal marketing structures exist.

While measures for preventing HIV/AIDS were prioritised at the beginning of the project, as planned, the development of brands for modern contraceptives was initiated at the same time (particularly the pill and condoms for family planning). This also seems relevant considering that the measures for HIV/AIDS prevention provide general information regarding reproductive health too, in order to raise awareness about modern family planning methods among the population.

SM activities concerning HIV/AIDS take place alongside state programmes and are part of the multi-sectoral strategy for HIV/AIDS. The HIV/AIDS commission (TACAIDS) coordinates activities of donors and non-governmental organisations. Activities concerning family planning are coordinated directly with the Ministry of Health (Reproductive and Child Health Section). The Ministry of Health and the SM agency have signed an agreement for this purpose.

Summing up, it is important to point out that the project objective was and still is very relevant. However, from today's perspective, a stronger conceptual distinction regarding HIV/AIDS prevention and the prevention of unwanted pregnancies would have been expedient. The concept was further developed in the course of the project and during the subsequent phases, while alternative communication, distribution and marketing structures were integrated, especially regarding modern family planning methods (basic health institutions, private clinics, "outreach teams").

Relevance rating: 2

Effectiveness

The project objective was to improve the level of knowledge, attitudes and behaviour of the population towards risks of HIV/AIDS and other sexually transmitted diseases, and to spread knowledge regarding the prevention of these diseases as well as unwanted pregnancies. An additional goal was to improve the

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supply and demand of inexpensive, high-quality contraceptives. The table below shows the project objective indicators used for the evaluation:

Indicators/planned	**Ex-post evaluation/actual**
(1) Number of condoms sold. Planned: - 2009: 83.63 million - 2006 - 2009: 305 million	- 2009: about 70 million condoms - 2006 - 2009: about 300 million condoms - 2013: about 90 million condoms (including “stock out” in 2012) → Indicator basically fulfilled, rapid growth of total market.
(2) Sale of oral contraceptives Planned: 1.6 million during project implementation.	About 1 million oral contraceptives sold during project implementation (outside the project: another 5 million by other SM agencies). Sold oral contraceptives in 2013: 1.3 million (in 2010: 0.56 million). → Indicator not fulfilled, but overall increase in sale of oral contraceptives through SM.
(3) Number of men and women aged 15-24 indicating use of a condom during their last intercourse: a) Men: 50 % (2009) b) Women: 38 % (2009)	a) Men aged 15-24: 58.7 % (THMIS 2011/2012) b) Women aged 15-24: 57.6 % (THMIS 2011/2012) (Results refer to unmarried men and women). → Indicator fulfilled.
(4) Development of Couple Year Protection (CYP)	2008: 3.05 million CYP (of which sold via project: 0.45 million) 2010: 3.1 million CYP (of which sold via project: 0.7 million) 2012: 4.05 million CYP (of which sold via project: 1.0 million) Background information: around 20 million people aged 15-49 years → Increase in overall CYP/year. Increased diversification of modern family planning methods
(5) Prevalence of condoms (rural areas). Calculation: with a random sample, all rural selling points are tested for the availability of condoms, enabling the prevalence of condom use (“penetration”) to be determined.	2006: 40 %, 2011: 48 % → Increase in market penetration of condoms. (no data available for other contraceptives)

*Estimates for 2010, National Bureau of Statistics, June 2013

Differentiated indicator on use of condoms based on risk-taking behaviour:

Condom utilisation during last intercourse within the past 12 months **a) With non-marital, non-cohabiting partner**	**Condom utilisation in percent (THMIS)**		
	2003/2004	**2007/2008**	**2011/2012**
Women aged between 15 and 49	38.0	42.8	-
Women aged between 15 and 24	41.7	46.3	54.6
Men aged between 15 and 49	49.7	53.3	-
Men aged between 15 and 49	47.1	49	56.8
b) For paid sex			
Men aged between 15 and 49	58.0	59.9	52.9

Even though the intended sales figures for condoms as well as oral contraceptives were not achieved across the board, the utilisation of condoms by unmarried young people, also during high-risk intercourse, has increased and can be considered a positive development. The proportion of modern contraceptives, such as implants and injections that women increasingly request, is rising. This was confirmed during field visits. Nevertheless, cultural and religious factors are still a hindrance to the utilisation of modern contra-

ceptives. In addition, women still play a subordinate role in society and can rarely even decide by themselves how many pregnancies they wish to carry out.

Effectiveness rating: 3

Efficiency

The implementation period lasted 4 years, as planned, yet there was a delay of 6 months in the early stages. The following indicators are used, among others, to monitor cost-efficient implementation:

Indicator/planned	Ex-post evaluation/actual
(1) Costs*/SM products sold. Planned value for 2009: a) Costs*/condom: USD 0.095 b) Costs*/oral contraceptives: USD 1.20	a) USD 0.160 (2009); USD 0.090 (2013) b) No data available à Indicator for condoms not fulfilled during project implementation, but target ever closer since 2010 (in subsequent phase).
(2) Total costs for CYP (all contraceptives)**. Planned: < USD 10	2011: USD 33, 2012: USD 10.5, 2013: USD 10 à Indicator suggests a positive trend.
(3) Total cost coverage, condoms: Planned at project appraisal: 8.5 %	Total cost coverage, condoms: target value reached during project implementation. (Increased during subsequent phase, despite greater activity in rural areas). 2010: 8 %, 2011: 24 %, 2012: 15 %, 2013: 15 %. Total cost coverage of other contraceptives: very low 2010: 1 %; 2011: 1 %; 2012: 10 %; 2013: 2 %.

* Costs for acquisition and marketing

** Value refers to total costs of FC project, which are spread over all SM contraceptives sold during the project

For one Couple Year Protection (CYP) consumers spend about USD 4.85 on the most favorable SM condom brands. The price is below the maximum price of USD 5.3 calculated by the Chapman Index. The more expensive SM brands cost between USD 7.28 and USD 9.70 per CYP. The retail price of the low-priced SM condoms is therefore appropriate for the poorer rural population. Privately sold condoms (Rough Rider, Durex) cost a lot more (about USD 50 per CYP). The costs for the SM pill per CYP amount to USD 2.7. These costs seem to be appropriate for the poor rural population as well, or rather slightly over-subsidised, yet for the urban population they are markedly over-subsidised.

The distribution system is supported by 5 zonal and 15 regional SM teams. In the past few years, strategies have been reformed from a push towards a pull strategy (marketing was predominantly handed over to existing marketing structures; with less priority on own brands). Sales took place via a strict control system with regional distributors, which transported the products from the capital to the regions and therefore received a fixed transport rate from the SM agency. Products reached consumers via wholesaler and retail merchants (partly also via local NGOs). The price for condoms and other contraceptives is specified by the SM agency and is reportedly adhered to by the merchants.

The market share of commercial condoms is very low at just 2 %. In 2012 some 62 % of the condoms distributed and sold in Tanzania were from the SM market, while 36 % were given out for free by the Ministry of Health. According to statistics of the Demographic and Health Survey (DHS 2010), however, the market's distribution is not consistent with actual use: the survey reveals some 83 % of respondents used an SM condom during their last intercourse, while only 9.6 % of the respondents used a free condom (in cases where a condom was used). Assuming these statements are accurate (people generally do not admit to using free condoms as easily), this confirms a higher utilisation rate of SM condoms.

The market for other modern contraceptives is dominated by the public health system (in 2012 about 65 % of oral contraceptives were distributed by the public health system). Nevertheless, the SM market is gaining in importance, especially due to common supply shortages in the public sector. That said, the SM market is reaching its limits in terms of the three-month injection, the contraceptive coil and implants, because so far only "licensed" providers were allowed to offer these products. Key distributors of the SM

agency network are hitherto excluded from that particular market ("ADDOs", accredited drug dispensing outlets), especially in peri-urban and rural regions.

The SM agency still holds the rights to the brands of condoms and contraceptives that it has developed. Furthermore, it continues to invest in the further diversification of its brand structure for condoms to cross-subsidise cheaper SM brands through more expensive SM condom brands that meet the prices of commercial brands. SM brands still dominate communication activity, which possibly enhances the image of inferiority particularly with products distributed freely.

Whether a reduction in the highly subsidised sale of SM condoms in favour of free condoms makes sense cannot be definitively determined based on current information, since there are no comparative values available for a cost/benefit analysis of the public health system. Several dialogue partners of the evaluation mission held the opinion that it was reasonable for end-consumers to contribute to the costs of contraceptives, as this promotes a higher utilisation rate for free condoms (allocation efficiency). Free contraceptives should only be handed out to the really poor population, especially given the limited resources in the health sector. Nevertheless, accurate targeting is a huge challenge. It is possible that efficient educational work and supply can only be achieved through the closer integration of the public system and the SM approach. Due to the rather weak production efficiency (acquisition and distribution costs) combined with good allocation efficiency; the overall efficiency of the project is assessed as satisfactory.

Effectiveness rating: 3

Impact

The overall objective was to contribute to improving reproductive health by reducing HIV infections and to reduce the number of unwanted pregnancies by ensuring individual freedom of choice. The following indicators are used as guidelines for the assessment.

Indicator	Status at ex-post evaluation
(1) Decline of HIV/AIDS prevalence a) Overall average: 7 % (2005) b) Women aged 15-49: 7 % (2008) c) Men aged 15-49: 6.0 % (2008)	a) Overall average: 5.1 % (2011/2012) b) Women aged 15-49: 6.2 % (THMIS 2011/2012) c) Men aged 15-49: 3.8 % (THMIS 2011/2012) → Slowly/clearly declining trend
(2) Reduction of birth rate (TFR) Status 2005: 5.7 children/woman (15-49)	2002: 6.3; 2003/05: 5.7; 2008/10: 5.4 → Slowly decreasing trend: target value for the Tanzanian government 2015: 5.2.
(3) Contraceptive prevalence (only modern contraceptives, married women) Target for the Tanzanian government for 2012*: 30 %	2005: 19.5 (DHS); 2010: 27 % (DHS) → This value has nearly quadrupled since 1991/92 and is now slightly above the sub-regional average (9 countries).

*Midterm Analytical Review of Performance of the Health Sector Strategic Plan III 2009-2015, 2013

The project contributed directly to MDG 6. HIV prevalence has decreased in past years, although the lifespan-extending effect brought on by antiretroviral therapy has counteracted this. Due to fewer incidences of HIV among 15-49 year-olds (1992: 1.34 %, 2000: 0.64 %, 2012: 0.32 %) it can be assumed that the positive trend in the prevalence rate will continue. The fact that condom use has become normal ("we made condom use normal") is an important achievement of the project (and the SM agency). Given the cultural and religious reservations (Muslims, Catholics) this posed a tremendous challenge. The acceptance of the SM condom brand Salama is high among the population. Salama was introduced as a new term for condoms in Swahili (Salama means security in Swahili).

The project also contributed to improved reproductive health, though the results were below expectations. The development and market introduction of further brands for family planning took more time than originally intended. The birth rate is only declining slowly. The uncovered requirement for contraceptives among married women remains high at 20 %. Additionally, the education and availability of modern family planning methods seem insufficient, especially in remote areas. The topic of female self-determination over their body and sexuality has not been picked up comprehensively enough, particularly against the

backdrop of cultural and religious factors. Due to the relatively rapid effects of the project on reducing the HIV/AIDS prevalence rate and the important change in attitudes resulting in higher contraceptive prevalence (establishing the brand name “Familia” for all modern family planning methods that are offered by the SM agency; market rollout of the pill and a condom for married couples with this brand name), the overall developmental impact is rated good.

Impact rating: 2

Sustainability

The Tanzanian government published a third multi-sectoral strategy for HIV/AIDS in November 2013 for the years 2013/14 until 2017/18 (NMSF III). The prevention of HIV/AIDS is still one of the main priorities. A balanced supply of condoms (free as well as sold condoms) should be ensured for all target groups. The financial sustainability of the strategy is vague. According to the NMSF III, some 71 % of resources for HIV/AIDS come from multilateral donors, first and foremost USAID and The Global Fund. Only the USA allocates more than 70 % of all donors financing to the area of HIV/AIDS (USD 362 million per year). Taking into account the diminishing resources provided by donors, the government of Tanzania faces a huge challenge to develop a sustainable financing strategy to combat HIV/AIDS. It remains to be seen whether the current beneficial economic growth (4 % per year) will be used to reduce the still high dependency on donors in the coming years. Furthermore, the subsidy element for SM products is very high – no change expected here for the next few years – even though the increasing number of SM products on the overall condom market proves the willingness of consumers to pay a certain share by themselves. This can still be developed in the future. However, educational and sales activities will still be dependent on considerable external financing in the future.

Developing the range of modern contraceptives represents a key step towards the institutional sustainability of the family planning component. This is implemented with two strategies: (1) Expansion of the private service provider network for family planning in urban areas via social franchises, and (2) free family planning services provided by “outreach teams” in rural, remote and under-supplied areas. However, the financing for these activities remains mostly external.

The SM agency works very professionally. Staff fluctuation is low and they are highly motivated. The agency maintains good relations with competing SM agencies, state agencies and institutions, and plays a key role in important bodies of the public health sector for HIV/AIDS and family planning. The SM agency succeeded in finding new topic areas and donors, and thereby securing a certain degree of sustainability for the agency. Through ongoing development, adjustments and integrating with other SM agencies, the institutional sustainability can be ranked as relatively good.

Sustainability rating: 3

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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).