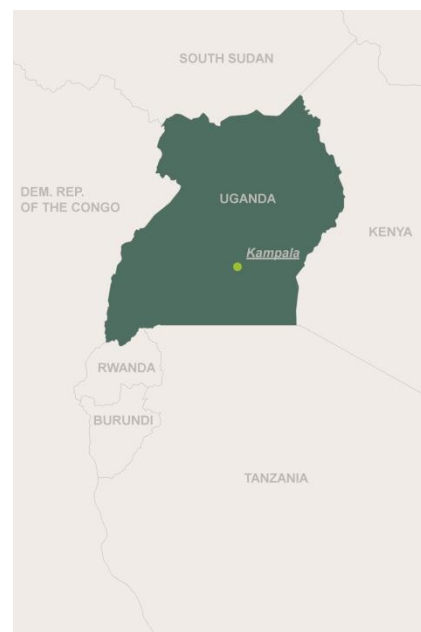


Ex post evaluation – Uganda

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Sector: STD control, including HIV/AIDS (13040)
Programme/Project: Programme to combat sexually transmitted diseases III, BMZ No. 2001 65 308*
Implementing agency: Ugandan Ministry of Health (MoH) / Social Marketing Agency



Ex post evaluation report: 2015

		Project (Planned)	Project (Actual)
Investment costs (total)	EUR million	6.06	6.29
Counterpart contribution**)	EUR million	0.56	0.81
Funding	EUR million	5.50	5.48
of which BMZ budget funds	EUR million	5.50	5.48

*) Random sample 2015, **) Condom sales revenues / STD vouchers

Summary: This FC serial programme was designed to reduce new infections with HIV and sexually transmitted diseases (STD) in Uganda. In Phase III (2005-12) of the programme launched in 1995, the social marketing of condoms as well as awareness and advertising campaigns were supported nationwide to urge the population to deal with HIV/AIDS properly. Additionally, a voucher system for the diagnosis and treatment of STDs in south-west Uganda was funded as a pilot scheme.

Objectives: (A) Supplying condoms to the target-group in line with their needs and implementing communication measures were designed to help the nationwide population protect itself better from HIV infection and other STDs. (B) The treatment vouchers for STD patients were aimed at giving particularly poor segments of the population access to the services of private local health-care facilities. This pilot measure was designed to trigger further steps for the establishment of a sustainable health-care financing system in Uganda.

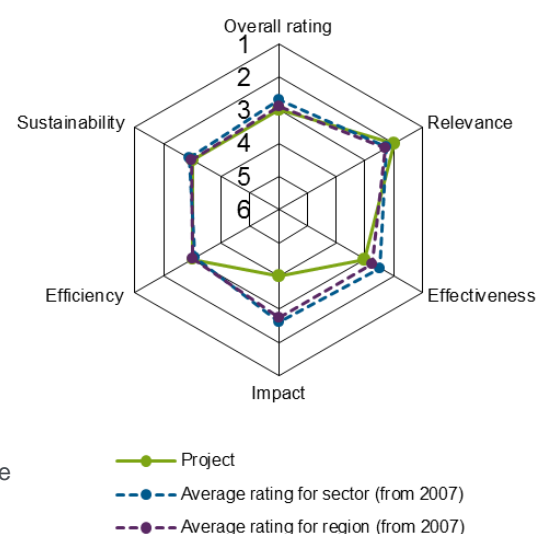
Target group: The target group was the population of Uganda aged between 15 and 49, focusing on young women and girls as well as at-risk groups, and - in terms of the pilot components - on the sexually active population in the south-west of the country.

Overall rating: 3

Rationale: Although the social marketing measure did not make the anticipated contribution to preventing HIV/AIDS and thus the overall impact was evaluated as no longer satisfactory, the innovative character of the pilot voucher project implemented means the overall rating is satisfactory.

Highlights: After a sharp decline in the HIV prevalence rate in the 1990s and 2000s, it has been rising again since 2010.

The availability of drug treatment for HIV/AIDS means that the incentives to take action at individual and macroeconomic level are diverging: individuals have less motivation to avoid an HIV/AIDS infection. By contrast, the Ugandan state has a vested interest in reducing spending on HIV/AIDS, which accounts for roughly one third of the national health budget. The costs attributable solely to the treatment of HIV/AIDS and thus far financed largely outside the budget already exceed the entire national health budget by far.



Rating according to DAC criteria

Overall rating: 3

Relevance

The overarching development objective of the programme to reduce the spread of HIV/AIDS and sexually transmitted diseases by 25 % each met the health-care priorities of the Ugandan government at the time of the programme appraisal and still does today. The government is aligning with relevant regional initiatives such as the Abuja Declaration (2001), the Maputo Plan of Action (2006) and the Africa Health Strategy (2007-15), all of which comprise measures for universal access to services related to sexual and reproductive health. Additionally, the programme approach is consistent with German and international development policy priorities, especially MDG 3 (promoting gender equality and empowering women) and MDG 6 (combatting HIV/AIDS).

A distinction must be drawn between components to evaluate the results chains underlying the programme: (A) The supply of good-quality and affordable condoms based on the needs of the target groups along with awareness measures had the potential to offer the target groups - especially those at risk of HIV - better protection against infection with HIV/AIDS and other STDs. Focusing on the sale of "own" condom brands instead of promoting the development of the entire market did reduce the relevance. (B) Measures to raise awareness regarding STDs, which constitute a "gateway" to HIV/AIDS infections, and the marketing of subsidised STD vouchers provided access to advice, medical diagnoses and the treatment of STDs, including HIV/AIDS, for a part of the population that had so far been excluded on account of their limited ability to pay. Thanks to the obligation embedded in the system to buy two vouchers, which thus inevitably brought partners into the fold, an innovative system was introduced for "couples' treatment". This strength of the system compensates for the weakness found in neglecting the "total market approach", which means the relevance is still considered good.

Relevance rating: 2

Effectiveness

The programme objectives were to supply the target group with high-quality condoms at reasonable prices, develop new concepts for the efficient and effective provision of medical services, achieve significant changes in sexual behaviour and reduce discriminatory behaviour against those affected by HIV/AIDS. The attainment of the project objectives defined at the project appraisal can be summarised as follows:

Indicator	Status PA***	Ex post evaluation
(1a) Sale of 42 million FC-funded condoms (Lifeguard) over programme duration (1b) Total Ugandan market for condoms has grown	2006: (1a) 18 million Lifeguard condoms (1b) 105 million condoms in total	(1a) 45 million Lifeguard condoms sold → target achieved (1b) 82 million condoms in total in 2012; total market development stagnating or declining*) → Indicator not fulfilled
(2a/b) Sale and reimbursement of 35,000 STD vouchers	--	(2a) Sale: 39,878 STD vouchers (2b) Reimbursement: 31,658 (79 %) → 90 % of indicator fulfilled
(3) Share of women / men	2006:	2011:

aged between 15 and 49, who used a condom during last sexual intercourse with a non-regular partner, is rising	35 % of women 59 % of men	36 % of women 58 % of men → Indicator not fulfilled
(4) Share of young people aged between 15 and 24 who used a condom in the last sexual intercourse is rising	2006: 40 % of women 56 % of men	2011: 54 % of women 63 % of men → Indicator fulfilled
(5) Share of young people aged between 15 and 24 who know that condoms and only having sexual intercourse with a non-infected partner protects them from HIV/AIDS is rising	2006: 68 % of women 79 % of men	2011: 74 % of woman 79 % of men → Indicator fulfilled for women / not for men
(6) Share of women / men aged between 15 and 49 who know that using condoms protects against HIV infection is rising	2006: 70 % of women 84 % of men	2011: 79 % of women 84 % of men → Indicator fulfilled for women / not for men
(7) Share of target groups who are discriminated against or have stigmatising views is falling	--	Proxy indicators used**) confirm clear decline in discrimination against those who are HIV positive → Indicator fulfilled
(8a/b) The contraceptive prevalence rate of married women aged between 15 and 49 has risen and the unmet demand for family planning has fallen	2006: (8a) contraceptive prevalence rate: 24 % (8b) unmet demand for family planning: 38 %	2011: (8a) contraceptive prevalence rate: 30 % (8b) unmet demand for family planning: 34 % → Indicator fulfilled

*) Sources: Study on Condom Market Development (UNFPA-PSI 2012), National Condom Programming Strategy 2013-2015, Ministry of Health of the Republic of Uganda; DHS Uganda 2006 and 2011; **) willingness to care for an HIV-positive relative in one's home; willingness to disclose the infection status of a relative to one's social circle; ***) PA: Programme appraisal.

The programme's target indicators were only partially achieved. The overall market for condoms is stagnating. Significant social trends underlying the indicators referred to above are pointing in the right direction: the awareness that using a male condom can prevent an infection is relatively high. The stigmatisation of people with HIV has fallen sharply, and there are signs of progress with the sexual self-determination of women. At the same time though, there have been few positive changes in the sexual behaviour of men. Changed incentives brought on by the availability of anti-retroviral therapy (ART) stand in the way of this fundamental shift in attitude that is required. HIV infection is no longer the "spectre" it was in the past, so a change in behaviour seems less vital for survival.

It is encouraging to note that the voucher system has been accepted and it has prompted testing and treatment among poorer parts of the population. The targeted "couples' treatment" was also achieved in almost 80 % of the cases. This is a key factor in curing STDs and ensuring future protection against infection with an STD or HIV/AIDS. This is why the effectiveness overall is deemed satisfactory.

Effectiveness rating: 3

Efficiency

A distinction must be drawn between production efficiency (output/euro) and allocation efficiency (impact/euro) in order to measure the efficiency of the programme. Furthermore, we also differentiate between component A (almost 60 % of FC funds) and B (roughly 40 % of FC funds).

The total implementation period for the measures was roughly 8 years and therefore much longer than the 3.5 years planned. This was primarily due to delays in the preparations for pilot component (B), which had to be developed on patchy information from the government and other inexperienced service providers (for monitoring and billing) for the accreditation of private service providers.

Sales of social marketing condoms ("Lifeguard" brand) were handled on sub-district level by the Social Marketing Agency (SMA) itself. This required a relatively high deployment of staff with a limited reach (four teams each with two people for the entire country) and took place in parallel to the distribution of other social marketing condoms (two other SMAs), which covered comparable market segments to a large extent. This market situation triggered fierce competition for market share, which was detrimental for the overall market development, particularly for cost reasons. The brand rights for the subsidised social marketing condoms are held by the respective SMAs. All told, the three SMAs shared roughly 25 to 35 % of the total market (with the exception of 2010: almost 50 %, following a sharp slump in free condoms, which led to the overall market shrinking by more than a quarter). On average, 60 to 70 % of the market was covered by free condoms and 2 % by 16 different commercial brands in the high-price segment.

The end-consumer price for the "Lifeguard" social marketing condom (FC-funded) was around EUR 0.31 in 2015 (pack of 3) and accounted for the largest share of social marketing condoms between 2006 and 2012¹. The price of the other social marketing brand "Protector" is around EUR 0.15 today, and the same applies for the 3-pack of "Trust", which controls the smallest share of social marketing condom sales. This means the current end-consumer prices for a couple year of protection in relation to two of the three social marketing brands are just below the Chapman Index of 1 % of average GDP per capita. The costs of the Lifeguard condoms amount to nearly 2 % of this average value - a price that is adjusted to the principally urban distribution region. Both of the cheaper brands are quite over-subsidised for this area, as the local poor population mainly tend to use free products. Likewise, the rural population largely seems to resort to using the condoms provided free of charge, or in some cases have no access to condoms whatsoever. The over-subsidisation referred to above is most certainly connected to the battle for market share in the social marketing segment. The adjustments made to "Lifeguard" prices during the programme implementation exceed the inflation rate (2006-11: roughly 166 %) and also reflect the real growth in GDP per capita.

Roughly 19 % of the total SMA costs were covered by sales proceeds for condoms in component (A). The SMA costs to supply one condom (i.e. without dealer margins, which make up approximately 95 % of the end price) total approximately 9 eurocents - a rather low value by African standards. With the pilot component focusing on STD prevention and treatment, the sales proceeds amount to 0.4 % of the total costs of the component, while the direct costs for health-care services amount to USD 11.45 per treatment; the latter corresponds to nearly 20 % of the total cost of the pilot component (USD 44 per sold voucher). This figure still seems appropriate given the comprehensive start-up activities required for the selection and quality assurance of the 28 accredited service providers.

The allocation efficiency is hindered by the fact that (A) the overall condom market could not be expanded in the course of the programme - even the slump in the supply of free condoms could not be compensated for by social marketing condoms. What is very encouraging, on the other hand, is the short implementation time of pilot component (B) at 13 months, which indicates significant demand. In short, the efficiency of the programme is considered to be only just satisfactory given the dominance of component (A).

Efficiency rating: 3

¹ Condom Market Study, PACE et al, 2012

Impact

The overarching development objective of the programme was to reduce the spread of both HIV/AIDS and sexually transmitted diseases. The following indicators are used for the assessment:

Indicator	Status PA*	Ex post evaluation
(1) Reduction in HIV/AIDS prevalence rate by 25 %	2005: 6.4 %	2011: 7.3 %, 2013: 7.4 % → Indicator not fulfilled
(2a) Reduction in STD prevalence rate by 25 % (2b) Increase in their treatment	2006: (2a) 22 % of women / 13 % of men had STD symptoms in the last twelve months (2b) of which 63 % of women / 73 % of men sought medical treatment (2a) Syphilis prevalence rate among 15-49 year-olds: 3.1 % (2004/05)	2011: (2a) 27 % of women / 14 % of men had STD symptoms in the last twelve months (2b) of which 69 % of women / 67 % of men sought medical treatment → Sub-indicator not fulfilled (2a) Syphilis prevalence rate among 15-49 year-olds: 1.8 % → Sub-indicator fulfilled

Sources: HIV and Aids Uganda Country Progress Report 2013, UNAIDS; 2011 Uganda AIDS Indicator Survey 2012; DHS 2006 and 2011; *) PA: Programme appraisal.

All told, the developmental impacts targeted were not achieved: after HIV prevalence was in decline for 15 years, it has climbed back above 7 % since 2010. Instrumental in this increase, in our view, is the life-prolonging drug treatment used for HIV-positive people, which is free via the public health system, the rising incidence and the HIV testing – heavily subsidised by the state if necessary – in combination with the improved collection of relevant data. This means that HIV/AIDS as a disease and the people infected by it have also become more noticeable.

The possibility of HIV/AIDS treatment and the free access to ART have led to a visible de-demonising of the disease and the removal of the fear factor in dealing with those who are infected. HIV/AIDS in Uganda has become a disease like any other, where sexual behaviour is seemingly characterised by a greater degree of neglect. Infections are rising sharply as a result of this development: since 2010 Uganda has recorded between 130,000 and 150,000 new infections per year, which infers an incidence of approximately 0.4 % (no reliable figures are available). At so-called "hotspots", such as rural roads leading to neighbouring countries, the current prevalence rates are reported to be between 9 and 19 %. Young people in particular are among those affected by the infection.

In terms of the voucher system it is encouraging to note that this pilot component succeeded in mobilising private capacities for health-care services benefiting the target group, and thereby developing a good example that is now being copied in other projects around Uganda. Nonetheless, the overarching impacts are no longer satisfactory.

Impact rating: 4

Sustainability

To evaluate this we need to explore the sustainability of the impacts per se as well as the financial and structural sustainability. Here too, a distinction must be made between components (A) and (B) to some extent.

Developmental impacts prevail only in partial areas. The increase in new HIV infections since 2010 highlights a trend reversal during the programme term. The behavioural changes achieved in terms of the objective (component A) - according to current information and local observations - continue to regress and preventive measures are on the decline, especially with young people, who did not experience the emphatic awareness campaigns of the 1990s and 2000s. Since those under the age of 30 make up roughly

70 % of the population, the overall trend is alarming. Awareness for the need to continue with education campaigns is currently as acute among participants in the health-care system as the helplessness when faced with the question of which communication strategies could bring about more responsible sexual behaviour under the present conditions.

The problem here is the completely contradictory incentives for action: the free access to ART does not really prompt individuals to change their behaviour. However, the Ugandan state is already unable to provide ART from its own resources; it depends on the "benevolence of donors" in this respect up to a level of 90 %, and cannot afford a further increase in the prevalence rate. In this context, the country had to spend eight times the amount of budget funds in 2012 that were spent on combating and treating malaria, which is the most common cause of death in Uganda. If these expenses on combating and treating the disease are allocated to the number of cases, the expense per person infected with HIV is nearly 40 times as much as for a case of malaria. This makes HIV prevention a renewed and much more complex challenge for health policy.

By contrast, the halving of the syphilis prevalence rate is encouraging, but it is being overshadowed by the current outbreak of Hepatitis B/C, which are also STDs. The spread of STDs overall is therefore unchecked, even though the information about the protective role of condoms is now widespread.

Financial sustainability is hampered by the fact that the positive development in HIV/AIDS prevalence rates in the last decade has prompted donors to turn away and far fewer funds are made available for education and awareness. The condom market, which is largely financed and subsidised externally, is stagnating and has suffered significant slumps. What is more, the three existing SMAs are focusing more on marketing their own brands - given the reduction in donor funding - and in some cases have cut prices (Lifeguard today costs EUR 0.31 for a pack of 3, compared to EUR 0.50 in 2012), at the expense of communication measures.

The achievements of the voucher systems have gone down after the phase-out of FC funding. The private practices which were expanded partly to handle these voucher services (patient admissions rising by 20 % up to a four-fold increase) have had to lay staff off - but they do continue operating on a smaller scale. Most of the "voucher patients", who were only able to afford doctors' visits and the quality examinations, consultations and treatment by buying these heavily subsidised services, did not become regular patients. This is because of their limited financial resources. The often poorly equipped public health facilities or isolated follow-up voucher initiatives can only be able to plug this gap to a certain extent.

Nevertheless, the voucher system did manage to raise awareness of the quality of health care services on offer, and primed the health-care sector as a whole for the important aspects of long-term financing systems (e.g. accreditation of service providers, setting standards, billing services). Subsequent voucher projects now offer public facilities the chance to get involved, provided they meet the required standards. In light of the model character of this pilot component, which pointed the way towards new opportunities as to how challenges in the health sector can be overcome, and given the existing structures, the sustainability is still rated as satisfactory.

Sustainability rating: 3

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

Rating levels 1-3 denote a positive assessment or successful project while rating levels 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. Rating levels 1-3 of the overall rating denote a "successful" project while rating levels 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" (level 3).