Ex post evaluation – Central African Republic

Sector: Rural development - 43040
Programme/Project: A - Sectoral Programme (BMZ No. 1995 67 041) *
B - Rural Development Ouham-Pendé III (BMZ No. 1999 65 914)
C - Rural Development Ouham IV (BMZ No. 2000 66 563) *
Implementing agency: Ministère de l'Equipement, des Transports et de l'Habitat, chargé du Désenclavement (MTP)

Ex post evaluation report: 2016

		Proj. A (Planned)	Proj. A (Actual)	Proj. B + C (Planned)	Proj. B + C (Actual)
Investment costs (total)	EUR million	8.44	8.02	5.86	6.06
Counterpart contribution	EUR million	0.77	0.35	0.00	0.20
Funding	EUR million	7.67	7.67	5.86	5.86
of which BMZ budget funds	EUR million	7.67	7.67	5.86	5.86

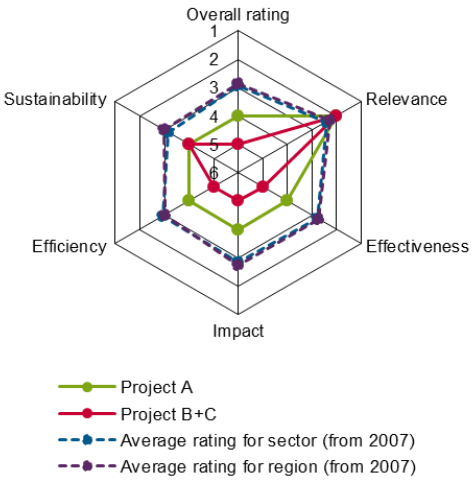
*) Random sample 2015

Summary: Originally a multi-sector development programme in the prefectures of Ouham-Pendé and Ouham ("Région Sanitaire"/RS 3) in the north-west of the Central African Republic (CAR), the concept was refocused on the health sector as a result of recurring crises and conflicts: equipping of health units in RS 3 and "social marketing" (nationwide) of condoms as well as supporting a youth and culture centre (CISJEU) in Bangui for education in reproductive health (Proj. A); rehabilitation and equipping of 94 basic health care facilities in RS 3 (Proj. B + C) via non-governmental organisations – including awareness campaigns, supply of consumer goods and training materials as well as the establishment of beneficiary committees.

Objectives: Improved health services and protection against sexually transmitted diseases such as HIV among others ("outcome") help to improve the economic and social situation ("impact") – primarily in the programme region, but also nationwide (via the "social marketing" components of project A).

Target group: In terms of the health facilities in programme region RS 3, the predominantly poor rural population with roughly 850,000 people in the catchment areas of the healthcare facilities concerned; for the "social marketing" components of project A, the sexually active population of the CAR.

Overall rating: 4 (Project A)
5 (Projects B + C)



Rationale: Widespread destruction and looting during the civil war that flared up again in 2013 have annihilated the projects' achievements in terms of infrastructure. For project A (which also supported health infrastructure in RS 3 with over 40 % of its budget volume) the evaluation is somewhat more favourable: its "social marketing" components (a good 50 % of the volume) at least contributed to a decline in HIV prevalence – though this cannot be quantified – and the structures built could and can be used for follow-up interventions in and around Bangui - at least to a limited extent. Health services in RS 3 have not completely collapsed according to information available: a good 45 % of the facilities have been partially or completely destroyed, but 48 % of all facilities at least offer basic services within the limits of their resources. Under the prevailing circumstances, a more precise assessment based on indicators is not possible.

Highlights: Even in a fragile, conflict-ridden environment with public service providers largely absent, the non-governmental structure chosen was still functional until the civil war newly erupted in 2013.

Rating according to DAC criteria

Overall rating: 4 (Project A)
5 (Projects B + C)

Overall context

The Central African Republic (CAR) currently holds a population of around 4.7 million, and has experienced multiple crises and conflicts since its independence in 1960. The persistent problems – as well as interference from outside the country- are attributable, at least in part, to conflicts over access to the country's primary resources (esp. diamonds and timber).

The CAR ranks low in both regional and international terms with respect to almost all development indicators – though the availability and reliability of the corresponding data are limited at best. The country was, e.g. ranked 185th out of 187 countries in the Human Development Index (HDI) in 2013, with an index value of 0.341 (by comparison in 1998: 0.371, ranked 166th out of 174), infant mortality (<5 years of age) is 140/1,000 and, at 49 years, life expectancy has been consistently low. Health care is focused primarily on the capital and its surrounding areas, and - according to the latest available figures (2009) - there are on average around eight health professionals (i.e. doctors and nurses) per 10,000 inhabitants. In the past two years, i.e. after the civil war flared up again in 2013, access to medical care has largely depended, especially in rural areas, on the presence of international aid initiatives and organisations. HIV prevalence among 15-49 year olds has fallen from over 10 % in 2000 to below 4 %, but there is uncertainty about the main reasons for this, i.e. whether primarily brought about by improved protection and education in contrast to increased HIV-related mortality. According to World Bank data, the illiteracy rate, estimated at 60 % in the late 1990s, had fallen to around 43 % by 2011 and continues to fall.

At the time of the programme appraisal (PA) of the various projects (i.e. between 1996 and 2001), the region had enjoyed relative stability for almost a decade, with conflicts mainly occurring in and around the capital city of Bangui. The civil war of 2002 and 2003 also affected rural areas however, and struck the north-western part of the country in particular (i.e. the original programme region). As a result, local activities – i.e. in the prefectures of Ouham and Ouham-Pendé (identical to the "Région sanitaire/RS 3") – were suspended and the staff withdrawn, after project staff two members had lost their lives under violent circumstances. The withdrawal of personnel was followed by looting in many places, and substantial property damage in some cases.In the following years (i.e. up until 2013), the local security situation remained tense: as a result, e.g., no KfW missions were possible in RS 3.

The takeover by Muslim "Seleka" troops in 2013 led, among other things, to confrontation with the non-Muslim "Anti-Balaka" militias and to an ongoing civil war with extreme violence, mass exoduses, destruction and looting at a large scale. Almost the entire country was affected, but the north-western part of the country – and thus the programme region once again – was hit particularly hard (with some parts still affected today). While peacekeeping forces have been stationed in the country by the United Nations and an interim government is in office, a comprehensive return to normality or stability can at best be expected in the medium-term, if at all. "Government action" - being largely dependent on external assistance - focuses on humanitarian relief and tackling acute crises[1].

Most of the country's health facilities were looted, with many demolished or destroyed, and the majority of staff fled. Despite all this, in 2014 and 2015 it was possible to carry out an exploratory survey – in part using telephone interviews – into the state of health care in all prefectures of the country. The findings of this research form the basis for the report presented here, which was compiled as a so-called "desk review".

The programme phases appraised between 1996 and 2001 were originally conceived as multi-sector projects in the prefectures of Ouham and Ouham-Pendé, in the north-west of the CAR:[2]

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[1] A. Mehler (2015): "ZAR - Politökonomische Kurzanalyse" [CAR - A Brief Politico-Economic Analysis]; German Institute of Global and Area Studies, Hamburg

[2] The previous phases I and II (BMZ nos. 1995 66 910 and 1997 65 744) were implemented in cooperation with TC, in the programme region managed by TC for many years, and were assessed as "no longer satisfactory" at the 2009 ex post evaluation (4).

- **Project A** (“sectoral programme”) was originally aimed at supporting healthcare measures (41 % of the budget), road construction (37 %) and the supply of drinking water (22 %) in the programme region. In fact, healthcare measures in RS 3 were financed, using around 41 % of the budget (health centres and equipment for Bossangoa regional hospital); furthermore, between 2000 and 2006 around 51 % of the funds were used to conduct a national campaign for the “social marketing” of condoms along with associated education. This was at the express wish of the government at the time, which had declared HIV prevention a priority; construction measures and the supply of equipment for an educational centre in the capital city of Bangui were also funded (8 % of the volume). Ultimately, neither road construction measures (supply of construction vehicles) nor the support for two water supply systems materialised; the latter was taken up by the French AfD.
- The sole focus of intervention for **projects B and C** was the improvement of social infrastructure (health and education) in the region. Before the projects were suspended (2002), around 39 % of the funds had been used in roughly equal parts to upgrade health units and schools. In addition, local committees were set up and trained to take care of building maintenance and the personnel costs for the operation of the facilities. This approach, followed from the outset, was aimed at compensating, at least to some extent, for the chronically weak state structures.
  From 2006 to 2008, activities in the primary education sector in the region were not resumed due to the almost total collapse of rural education; the commitment to primary health care was continued, however, with an emphasis on the maintenance and continued operation of existing healthcare facilities (approximately EUR 3.6 million, i.e. just over 61 % of the volume). Direct control by KfW was not possible due to the continuing critical security situation; nonetheless, the Italian non-governmental organisation COOPI and the Catholic charity CONASAN were still active in the region. The remaining FC funds available were used by these organisations to stabilise or improve a total of 94 healthcare facilities. The consultant (up until 2003) and the NGO COOPI (from 2006 onwards) also trained selected villagers as nursing assistants. After KfW missions in the programme region had to be terminated for safety reasons, the reporting – including the final inspection in 2012 – was based on reports and documents from COOPI and CONASAN as well as from local experts.

Relevance

Lack of access to primary education and health care was and is a key problem – as is the lack of transport links between large tracts of the programme region. The intervention logic - assuming that progress in these areas will at least help to improve the living conditions of the largely extremely poor population - remains plausible. The aforementioned constraints have been exacerbated by the dramatic deterioration in the country´s economic and social situation.

The project’s focus thus corresponds to important needs of the target group, and the basic concept is consistent with the development policy guidelines of the BMZ and the partner country´s priorities . This assessment also applies to the approach of providing services (health and education) via local committees or similar bodies on a self-help basis : self-help-oriented supply in rural areas, decentralised as far as possible and based - inter alia - on cooperation with NGOs, was a declared element of sector policy at the time. The weak public structures could only be strengthened to a very limited extent using this approach, however, and were instead replaced by external aid organisations in many places.

In 1999, at the government´s request HIV prevention was included in the design of project A; accordingly, a “social marketing” component was designed and implemented from 2000 onward. This was aimed at addressing the acute problem of high HIV prevalence at the time: according to UNAIDS estimates, over 10 % of the countries sexually active population was affected in the year 2000. In retrospect, the concept of the distribution or sale of condoms along with accompanying education (in this case using “social marketing”) has to count as a necessary approach – though not sufficient by itself – for alleviating the AIDS problem at the time. It is unclear from today's perspective to what extent state structures could have contributed in this context (possibly offering condoms at a discount or free of charge). Nevertheless, the project made it possible - even in times of crisis - to rapidly deploy programme funds via non-governmental structures in order to help remedy a problem considered urgent by all parties involved.

Although the security situation was given consideration in the initial risk assessment, it was deemed to be less serious - based on past experience (conflict centre Bangui) and the previous period of relative stabil-

ity (see above),. This assessment was refuted by the events from 2002 onwards and required a shift in the interventions priorities:

- Following the unrest mentioned above, project A used its remaining funds, i.e. just over half of the budget, to focus on HIV prevention through “social marketing” activities.
- In the case of projects B and C, the basic education component had to be abandoned (see above); given the continuing volatility of the situation, meaningful support was only possible through the above-mentioned stabilisation or improvement of healthcare facilities with the help of NGOs.

In view of the much more difficult conditions for implementation, this “re-design” can be considered an appropriate, context-specific response.

In retrospect, it remains unclear whether a stronger sectoral focus would have been more advisable than the multi-sectoral approach planned originally: according to information available, several donor organisations were active in the region, which possibly would have suggested a sectoral division of labour.

Relevance rating: 2 (all projects)

Effectiveness

The programme objectives defined at the appraisal comprise the dimensions of basic healthcare, primary education, transport and water supply. Since the area of primary education is dysfunctional and the issues of transport and water supply have been omitted completely (see above), the achievement of objectives can be assessed only in the area of health care – in relation to the healthcare facilities in RS 3 (projects A to C) on the one hand, and in relation to the “social marketing” component of project A on the other:

- The indicators defined for the healthcare facilities in RS 3 – (a) utilisation rate and (b) consultations in malaria cases – are, in principle, suitable for measurement, but were specified neither at appraisal nor in later stages. In fact, the prevailing security situation and the lack of available data[3] do not even allow for collecting such simple data in a sufficiently reliable way. It can be seen from existing documentation that 45 % of all healthcare facilities in RS 3 were partially or completely destroyed and that 48 % of the facilities (i.e. including some which were partially destroyed) offer at least basic services. According to the available information, 40 out of the 94 facilities funded under the projects were at least partially destroyed, with one completely destroyed; this is more or less in line with the above-mentioned overall ratio in RS 3. In the case of the “programme facilities” in particular, no information is available with regard to the supply of healthcare services, nor regarding the specific staffing situations (these are reported to be volatile in any case and, as a result, more accurate information would represent only a snapshot). However, the surveys carried out (not only in the case of RS 3) identify widespread staff shortages and insufficient budgets for drugs and consumables as key bottlenecks. In this respect, the civil war, displacement, destruction and looting did not permit to achieve the projects´ objectives, whose at least partial achievement was instead nullified due to the extraneous circumstances.
- Around 23.9 million condoms were marketed between the years 2000 and 2006 as part of the “social marketing” component of project A (around 51 % of the total volume), which corresponds to around 199,000 “couple years of protection” (CYP). A significant contribution could thus be made – at least temporarily – to the secondary objective of protecting against sexually transmitted diseases. This should be highlighted as a positive step in view of the tense national security situation from 2002 onwards. The accompanying educational campaigns´ effectiveness cannot be assessed conclusively due to the time that has elapsed and the security situation in the country. According to repors received, the main target groups of the campaign were adolescents and long-distance lorry drivers, while efforts to increasingly target sex workers were apparently met with only limited success. It should be noted that the marketing structures which were established in and around Bangui could and can still be used – albeit to a limited extent – in the FC regional project for HIV prevention for example, “‘CEMAC” (most recent phase IV, BMZ no. 2013 66 517).

[3] EPOS-Consult (2015): "Renforcement du Système de Santé ein République Centrafricaine - Étude de Pré-Faisabilité"; Bad Homburg World Health Organisation/ WHO (2014): "Health Resources and Availability Mapping System - Central African Republic"; Geneva

Overall, project A received a somewhat more favourable rating because of the “social marketing” component, i.e. the achievement of objectives is rated here as “no longer satisfactory”; however projects B and C have to be rated as “clearly inadequate”.

Effectiveness rating: Project A 4
Projects B+C 5

Efficiency

In retrospect, it was not possible to assess production efficiency with regard to the healthcare facilities (projects B and C, as well as parts of project A) in the absence of comparative figures. This does not apply in equal terms to the “social marketing” component of project A which, as determined at final inspection, incurred relatively high production costs (EUR 21.5/CYP)[4].

In terms of allocation efficiency, a rating of satisfactory had been expected in the area of healthcare facilities in principle, , given the significant commitment of the target group and of civil society organisations. However, these successes (understandably) did not survive the civil war escalating since 2013. As a consequence of the destruction that resulted from the civil war, major deficits can be identified in the results achieved with regard to healthcare facilities in RS 3, namely in terms of construction measures and supply of goods (all projects). For this reason, the use of funds is to be regarded as inappropriate, even though the dramatic worsening of the framework conditions could neither be foreseen ex ante nor be attributed to the project. The comments on the production efficiency of the “social marketing” component in project A also apply analogously to the allocation efficiency, assuming the - generally undisputed - link between condom use and the prevention of sexually transmitted diseases, particularly HIV.

Efficiency rating: Project A 4
Projects B+C 5

Impact

In analysing the programmes´ development impacts, the primary question to answer is the extent, to which the results in terms of basic health in RS 3 as well as nationwide HIV prevention have contributed to improved living conditions. In this context, supplying very poor people with basic health services is likely to have improved living conditions to a limited extent, at least temporarily (i.e. following the resumption of activities in 2006 until the beginning of the civil war in 2013). Furthermore, the self-help approach pursued in projects B and C contributed significantly to the – at least partial – effectiveness; according to all available information, however, this approach could not withstand the turmoil of the civil war. Moreover, it was not possible to help strengthen the already weak public structures. Accordingly, nothing remains to date of the at least partial impact achievement for projects B and C. In analogy to evaluation effectiveness (see above), project A´s impact assessment is slightly more positive: for one thing, according to information provided by UNAIDS, HIV prevalence decreased from over 10 % to just over 6 % in the period 2001-2006, which was probably due in part to a higher rate of patient mortality, but also attributable - at least to some extent - to HIV prevention measures, though this is not quantifiable; secondly, it has been possible to use the “social marketing” structures supported by project A for subsequent interventions, at least to some extent (see above).

Overall, we rate project A´s developmental impact I as "no longer satisfactory", with an "insufficient" score for projects B and C.

Impact rating:
Project A 4
Projects B+C 5

[4] For comparison: Tanzania, approximately EUR 10, Chad, approximately EUR 30

Sustainability

All projects are considered unsustainable with regard to health infrastructure - given the widespread destruction and looting which took place, as well as the virtually complete breakdown of state administration; this is also ultimately true for project A´s health facilities component, which spent almost half of the budget on healthcare facilities and similar premises (see above) which no longer exist. With regard to the “social marketing” component, however, it must be noted that the “Association Centrafricaine pour le Marketing Social” (ACAMS), which ultimately arose from the project initiative, is still in operation and will be used for follow-up projects.

Given the lack or near-total collapse of public structures after 2003, the user committees in RS 3 essentially constituted an appropriate approach for selectively counteracting structural deficits, to some extent at least, and enabling a minimum level of care – particularly since this work was supplemented by NGOs present in the region. These NGOs are now involved once again in facilitating at least rudimentary health care. Those services, however, are barely, if at all, integrated into (or interlinked with) state structures, which are faced with their own significant functional problems (see above). In essence, it can be concluded that sustained developmental results cannot be achieved without some basic assurance of ongoing operation on the part of the government. In this regard, even with foreign aid, CAR public structures would, at best, be able to achieve this in the medium-term.

Sustainability rating: 4 (all projects)

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).