KfW Development Bank

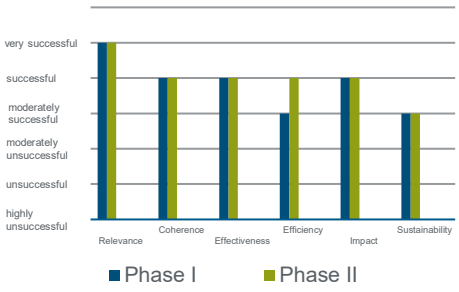
Ex post evaluation
Reproductive health, ECOWAS region

Title	Reproductive health and HIV/AIDS prevention		
Sector and CRS code	Family planning (13030) HIV/AIDS (13040)		
Project number	Phase 1 (Inv.): 2005 66 307, Phase 2 (Inv.): 2008 66 152 and Training 1930 04 355		
Commissioned by	German Federal Ministry for Economic Cooperation and Develop-		
Recipient/project-executing agency	Economic Community of West African States (ECOWAS) / West Africa Health Organisation (WAHO)		
Project volume/ Financing instrument	Phase 1: EUR 5 million; Phase 2: EUR 5 million; Training EUR 6,967.62; FC financial contribution (budget funds)		
Project duration	Phase 1: 09.2007- 08.2017; Phase 2: 10.2009 - 08.2017; Training: 2008		
Year of report	2021	**Year of random sample**	2019

Objectives and project outline

By improving the availability of contraceptives and enhancing family planning services and prevention of HIV/AIDS to better meeting demand (outcome), the project aimed at contributing to improving sexual and reproductive health and rights (SRHR) in the ECOWAS region (impact).
To this end, a regional financing mechanism was established for the procurement of contraceptives and for strengthening the capacity of governmental and non-governmental implementing organisations in SRHR. The regional approach targeted all ECOWAS member states, with initial priority for the five pilot countries Benin, Burkina Faso, Ghana, Guinea-Bissau and Niger.

Overall rating:
Successful



Key findings

The project was highly relevant and is rated “successful” due to its important contribution to improving the environment for SRHR in the region and for contributing to the enhanced access to SRHR products in the pilot countries, but also for strengthening regional cooperation in SRHR.

- The interventions of the regional project were complementary to existing national programmes and served as a catalyst to reposition family planning in the region.
- The use of both private sector and community-based distribution structures improved the availability of SRHR products and increased the effectiveness of interventions.
- The efficiency of the project has improved since the first phase, when the new funding mechanisms were established, but could be further increased by focusing on “high-impact practices” and strengthening joint regional product procurement.
- Important SRHR funding shortfalls in the pilot countries were bridged under the project and it is plausible that the project contributed to the objectives at impact level.

Conclusions

- Newly establishing a regional funding mechanism requires considerable time and resources.
- The approach was exemplary and appropriate for effectively improving sector policies at regional level as well as in the member states.
- An important factor in the success of the project is the high level of ownership of the executing agency WAHO, supported by targeted consulting services.
- The total market approach should be increasingly implemented to promote the efficiency and sustainability of interventions and reduce the divide between unmet demand and use of SRHR services, especially among young women.

1 = very successful, 2 = successful, 3 = moderately successful, 4 = moderately unsuccessful, 5 = unsuccessful, 6 = highly unsuccessful

Rating according to DAC criteria

Overall rating: 2

The two phases were jointly evaluated and, if required, separately rated.

Ratings:

DAC criteria	Phase I	Phase II
Relevance	1	1
Coherence	2	2
Effectiveness	2	2
Efficiency	3	2
Impact	2	2
Sustainability	3	3

General conditions and classification of the project

The project was planned in 2006 as a multi-phase, open programme together with other technical partners and donors (including USAID, CIDA). A two-day kick-off workshop was held in Frankfurt in March 2008 as part of basic and advanced training measure. The regional funding mechanism was developed in the 1st phase (2008-2013). This included both a fund for procuring sexual and reproductive health (SRH) supplies (FAP[1]) and a fund for strengthening the capacity of various stakeholders and promoting measures to improve the supply and demand of SRH services (FRC[2]). The resources of the two funds were deployed for national measures through an application process. In the first two phases, five pilot countries were supported: Benin, Burkina Faso, Ghana, Guinea-Bissau and Niger. In addition, the project funded various regional activities targeting all 15 ECOWAS countries: such as cross-border SRH educational campaigns, training and networking of social marketing organisations (SMOs). The 2nd phase (2013-2014) intensified and expanded these measures. The project executing agency was the West African Health Organization (WAHO), the health institution of the Economic Community of West African States (ECOWAS). The regional approach aimed to improve access to SRH products at national level. Furthermore, the objective was to strengthen regional, political and programme cooperation in the area of SRH through WAHO and increase the significance and effectiveness of SRH policies in the ECOWAS region. The original impact matrix was changed several times over the course of the 1st phase, the “design and setup phase”, as it were(2008-2010); it was not possible to analyse the reasons for these changes during the ex post evaluation. The programme objective at outcome level as of 2010 was to improve the availability of contraceptives and to enhance meeting the demand for family planning services. This implicitly included the prevention of HIV/AIDS and sexually transmitted infections as important SRH components.

Breakdown of total costs[3]

		Phase I (Planned)	Phase I (Actual)	Phase II (Planned)	Phase II (Actual)
Investment costs	EUR million	5.44	4.998	5.77	4.963
Counterpart contribution	EUR million	0.44	0.088	0.69	0.003
Budget funds	EUR million	5.00	4.91*	5.00*	4.96**

* Remaining FC funds of the 1st phase totalling EUR 86,905.23 were transferred to the 2nd phase and
** Remaining FC funds totaling EUR 126,899.29 to the 3rd phase (the latter is not part of this evaluation)

[1] Fonds d’Achat des Produits Contraceptifs.

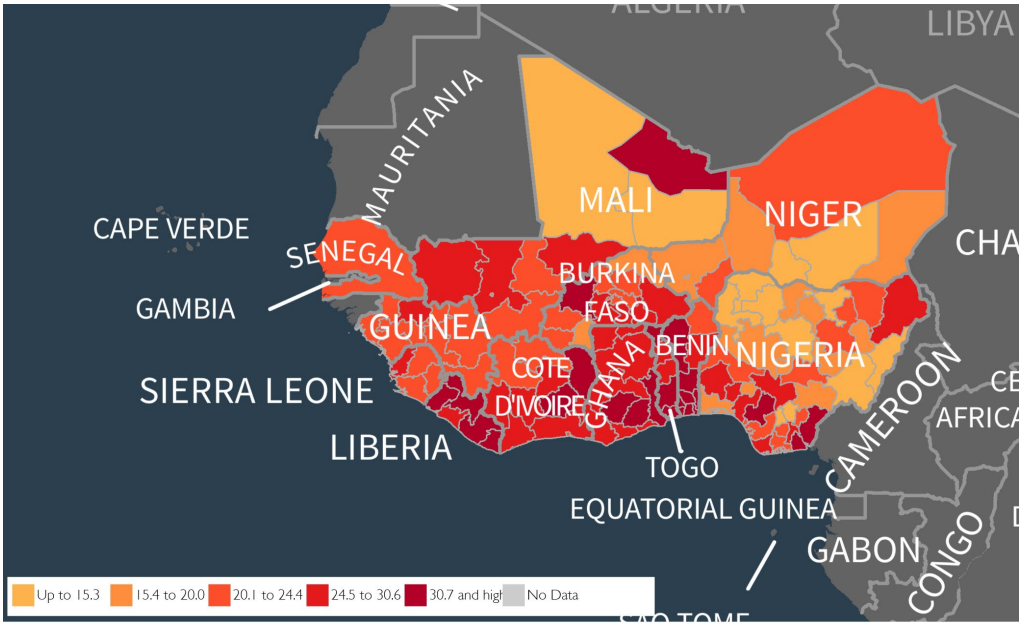
[2] Fonds de Renforcement des Capacités.

[3] Plus basic and advanced training measure totalling EUR 6,967.62 in budget funds.

Relevance

The ECOWAS member states are among the countries worldwide with alarming social and economic as well as poor health indicators. At the time of the programme appraisal, about half of the population (of a total of 270 million) lived in absolute poverty. High population growth, low education levels and weak economic performance endangered the sustainable economic development of most member states. Internal crises and military conflicts weakened the stability of the region. Birth rates and maternal and infant mortality rates were extremely high by international comparison. Only about 8% of married women used modern contraceptives. About one in four women in West Africa had unsatisfied family planning needs at the start of the programme. There are still considerable intra-country differences as shown in Figure 1.

Fig. 1: Unsatisfied need for family planning services among women in longterm relationships



Source: Statcompiler 2020, data based on the most current national Demographic Health Surveys (DHS)

Despite a declining birth rate, the fertility of the ECOWAS member states, with the exception of Cape Verde, is still 4 children per woman, in Niger it is even close to 7. The population continues to increase in all member states (except Cape Verde) between 2-3.8% per year.

Both the feminisation trend of HIV/AIDS and the HIV prevalence rates among at-risk groups were alarming. Côte d'Ivoire and Guinea-Bissau were hardest hit, where 4.6% and 3.9% of adults respectively were HIV-positive. According to UNAIDS estimates, more than 2.7 million inhabitants of the ECOWAS region were infected with HIV in 2008. Due to the traditionally strong mobility between coastal and landlocked countries, which intensified as a result of political crises, there was a high risk that HIVwould spread further.

Given the social, health, economic and demographic context of the ECOWAS countries, the design of the regional programme was highly relevant. The institutional integration of the project at WAHO was the key to success for the further development of national and regional SRHR policy and extended German FC. As a neutral actor, WAHO was able to shape policy dialogue on SRHR and to contribute to the regional integration of SRH issues. From the start, the regional funding mechanism intended to attract additional governmental and non-governmental donors for co-financing.

The theory of change (TOC) of the programme is plausible. Improved regional cooperation was expected to lead to an increase in the provision of SRH supplies, especially contraceptives, as well as to enhanced efficiency due to lower transaction costs. Consequently, the programme contributed to increasing the contraceptive prevalence rate, which in turn was expected to reduce maternal and infant mortality and HIV incidence. Cross-border campaigns and product marketing were intended to reach high-risk groups for HIV/AIDS more effectively, thereby reducing the incidence of HIV. Lowering the cost of procurement and

increasing the sustainability of funding was expected to lead to increased supply and thus greater use of contraceptives. Improved general conditions at both national and regional level aimed to contribute to the achievement of national programme objectives and thus to the improvement of SRHR in the region.

Self-determined family planning did not have the same priority as the fight against HIV/AIDS, therefore significantly less funding was available for family planning both at national and regional level. The emphasize on self-determined family planning concerning the use of the programme funds thus was particularly relevant. Synergies could be realised by integrating HIV prevention and family planning into national and supra-regional measures.

From today's perspective, the project's design addressed central core problems of SRHR in the region and was adequate to achieve the intended module objectives. The relevance of WAHO as a key stakeholder in strengthening SRHR in the ECOWAS region and WAHO's role as a multiplier exceeded expectations. The relevance of both programme phases is therefore rated as very good.

Relevance rating: 1 for both phases

Coherence

The project supplemented German bilateral and multilateral cooperation activities in the health sector in different ECOWAS countries. The social marketing programmes[4] (HIV-AIDS control and family planning) financed from bilateral FC funds were thus gradually integrated into regional coordination through WAHO. This has generated synergies and strengthened the sustainability of the approach. The focus on contraceptive procurement and capacity development complemented other TC projects in eight ECOWAS countries. Measures to combat HIV/AIDS aimed at prevention, and supplemented the interventions supported by GFATM[5] and PEPFAR[6].

The regional programme was consistent with the German Federal Ministry for Economic Development and Cooperation's health sector concept and the position paper on sexual and reproductive health, as well as with the overall goal of global poverty alleviation formulated in the 2015 Programme of Action. It further contributed to the realization of the human right to sexual and reproductive health in line with internationally agreed SPHERE standards.[7.]

The project was aligned with national, regional and international priorities. The programme intended to contribute to the achievement of the Millennium Development Goals MDG 3, MDG 5 and MDG 6, as well as to the respective SDGs.

The measures were subsidiary to WAHO's five-year strategic plan 2009-2013 and were consistent with the regional strategy[8] to improve the availability of SRH supplies and the regional HIV/AIDS strategy[9]. Many interviewees highlighted the significantly improved coordination and alignment of SRH interventions as a result of the FC project. The implementation of the regional financing mechanism required close coordination of governmental and private actors as well as donors and thus contributed to the implementation of the Paris Declaration of Aid Effectiveness.

The project supported the implementation of the national health strategic plans and the strategic plans for the supply security of SRH supplies, which, with the exception of Cape Verde and Côte d'Ivoire, were in place in all WAHO member states at the start of the programme. These strategies had been developed by the respective ministries of health, with the support of USAID or UNFPA.

The programme measures were complementary and consistent with regional and national objectives and strategies. However, as highlighted in many of the interviews, donor coordination could still be improved. In addition, since the programme started, various cross-regional programmes and initiatives[10] have been

4 Mali, Niger, Senegal, Burkina Faso, Guinea, Sierra Leone, Côte d'Ivoire and Benin.

5 Global Fund to fight AIDS, Tuberculosis and Malaria.

6 U.S. President's Emergency Plan for AIDS Relief.

7 Standards 2.1.1: Communicable diseases standard prevention; 2.3.1: Sexual and reproductive health standard reproductive, maternal and newborn healthcare. (www.spherestandards.org).

8 ECOWAS Strategic Plan "Reproductive Health Commodity Security, RHCS, 2007-2011".

9 ECOWAS Regional HIV/AIDS Strategic Plan 2012-2016.

10 Muskoka Initiative, Ouagadougou Partnership, SWEDD, FP2020, SECONAF.

initiated to boost support for SRH issues in different member states, adding further complexity to donor coordination . The coherence of both phases is rated as good.

Coherence rating: 2 for both phases

Effectiveness

The adjusted module objectives of the project were a) to contribute towards improved availability of contraceptives and b) to better meet demand for family planning services and, implicitly, to contribute to HIV/AIDS prevention. The ex post evaluation measured target achievement on the basis of the following adjusted indicators.

Indicator	Status PA (Phase I 2006, Phase II 2008) Goals	Ex post evaluation
(1) Increase in rate of modern contraceptive prevalence among women in relationships, 15-49 years old	**Phase I** ECOWAS[a] 8.1 % Benin 6.0 % Burkina 9.7 % Ghana 14.0 % Guinea-B. 6.0 % Niger 5.0 % **Phase II** West Africa[b] 9.0 % Benin 6 % Burkina 13 % Ghana 17 % Guinea-B. 6 % Niger 5 % [Goal: +1 % / year =>12 % since 2008]	Data for 2020c: West Africa 20.7 % (+12.6 %) Benin 14.0 % (+ 8.0 %) Burkina* 30.5 % (+20.8 %) Ghana* 29.9 % (+15.9 %) Guinea-B*. 19.8 % (+13.8 %) Niger* 20.1 % (+15.1 %) *Goal was reached in these countries
(2) New: Increase in rate of modern contraceptive prevalence among young women in relationships, 15-19 years old	Benin 9-5 % (DHS 2011) Burkina 5.9 % (DHS 2010) Ghana 12.1 % (MICS 2011) Guinea-B. N/A Niger 11.0 % (DHS 2011)	Benin 5.6 % (DHS 2017) Burkina 20.1 % (PMA[11], 2018) Ghana 32.6 % (PMA, 2017) Guinea-B. 7.1 % (MICS, 2014) Niger 11.5 % (PMA, 2017)
(3) Increase in couple-years of protection (CYP) (proxy indicator)	Status at PA = 0 Ph. I result: 895.001[b] Ph. II result: 483.367[b] [Goal: 500,000 CYP / phase]	1,378,368 CYP[b] Cumulative goal of both phases was achieved
(4) New: Number of countries with national budget line for SRH supplies + effective use of funds[12]	PP - Phase II Status[d] 2 / 15 countries: Burkina Faso, Ghana	"2019 Contraceptive Security Index Report" from November 2020[d]: 9 / 15 countries Benin, Burkina Faso, Cape Verde, Ghana, Guinea, Niger, Nigeria, Senegal, Togo

a) Data according to Hera basic study (2008); b) Data according to final review (2017); c) Data according to FP2020, West Africa =14 ECOWAS states not including Cape Verde; d) USAID Contraceptive Security Index

[11] Performance Monitoring for Action.

[12] Effective use of funds means that government funds were used to purchase contraceptives in the fiscal year.

Target achievement is rated positively overall. The fund even made it possible to provide more contraceptives than planned. At regional level, too, it is evident that four of the five pilot countries are now using their own funds to procure contraceptives, as are five other ECOWAS states.

The contraceptive prevalence rate reflects the availability and use of contraceptives. The use of modern contraceptives increased by at least 1 % per year among women of all age groups, with the exception of Benin, as expected. Burkina Faso made the most progress. Four pilot countries had set national targets of increasing contraceptive prevalence rates[13] by 2020 as part of the global FP2020 initiative[14]. Only Ghana was able to reach this target of 29 %, Burkina Faso came close to its target of 32 %. Niger was not able to reach the very ambitious target of 50 %, as did Benin, which had set a target of 22 %.

Indicator 2 also shows that the overall positive trend does not apply to younger women in all pilot countries. Significant improvement in the prevalence rate of young women can be seen in Burkina and Ghana. In Niger, however, the rate has hardly improved, and in Benin it has even deteriorated. These facts underscore the need for a greater focus of interventions to improve access to family planning services, especially for younger women. From an ex post perspective, it would have been important to disaggregate this data from the beginning to make it possible to identify and address inequalities at an early stage. In the first two phases, most of the measures supported by the Capacity Fund (FRC) did not specifically target youth and young target groups but addressed the general population. Only since the fourth phase began has the focus on young people been intensified, and a total of 40 % of all measures were directly targeting young people (the latter, however, is not part of this evaluation).

The contraceptives financed by the project through the procurement fund (FAP) achieved more than one million couple-years of protection in the first two phases (indicator 3), about one third more than planned overall. Condoms (45 %) and 5-year implants (22 %) accounted for the largest share. Condoms were not only extremely important for family planning, but also for the prevention of STI/HIV, as the example of Guinea-Bissau shows. Given the very low use of condoms for family planning[15], it is conceivable that the condoms supplied by the project for Guinea-Bissau - the pilot country with the highest HIV prevalence and incidence (around 7 million) - served primarily to prevent STI/HIV among younger, unmarried women.

The WAHO Regional Fund[16], which was initially only financed by FC, provided the pilot countries with 34 % and 78 % of the requested funds to reduce SRH funding shortfalls in the first two phases. This was due to the limited resources of the fund and the total volume of funds requested by the pilot countries.[17]

The involvement of national institutions and social marketing organisations (SMOs) in project planning and implementation, especially in the capacity-building measures, made a significant contribution to effective target achievement. In addition to the public health centres, private and community-based SMO distribution structures were used. At the same time, demand for SRH products and services increased as a result of interpersonal education campaigns and mass media. Improved communication and coordination of private and government actors in the national SRH measures made it possible to take important first steps towards the “total market approach”[18]. In an online survey conducted as part of this evaluation, staff from ministries of health, national procurement centres as well as non-governmental organisations (NGOs) and SMOs underscored the importance of regional procurement training, which contributed to key improvements in planning and national product procurement.

The project also fostered dialogue and cooperation between government and civil society actors at regional level. Together with other partners[19], for example, a regional early warning system was set up that provided regular reports on the availability of contraceptives, their expiry dates and future demand for products. Based on this data, products were transferred to avoid overcapacity and supply bottlenecks.

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[13] Relates to women aged 15-49 living in committed relationships.

[14] FP2020 was initiated in 2012 as a follow-up to the London FP Conference.

[15] According to the 2018-2019 UNICEF-MICS study, condoms accounted for only 2.5% of the FP method mix and only about 0.5% of the contraceptive prevalence rate among married women.

[16] The regional fund was co-financed by other donors in later phases (see Part 2).

[17] A total of EUR 10.3 million was applied for in phase I, which clearly exceeded the financial resources of the fund. In phase II, on the other hand, only EUR 4.9 million was applied for.

[18] This approach can strengthen the health sector in the long term by targeting free or subsidised products, reducing inefficiencies and creating room for the private sector.

[19] Reproductive Health Supply Coalition, USAID, World Bank and UNFPA.

The annual regional meetings also improved the exchange of experience and encouraged knowledge transfer on both programme-related and administrative issues. Individual cross-border campaigns reached mainly mobile target groups with information and services and highlighted the importance of SRHR to the public.

WAHO's advocacy work reinforced the prioritisation of sexual and reproductive health in the region and successfully improved the effectiveness of relevant sector policies. This can be seen, for example, in the added proxy indicator 4. SRH supplies are now co-financed by national budgets in nine countries. Important success factors for target achievement were the distinct ownership assumed by the executing agency and the excellent work of the programme management unit, which was unanimously acknowledged by all interview partners. Despite considerable bureaucratic hurdles and the complexity of the project, WAHO, with the expert support of the international consultant, managed to successfully set up and expand the financing mechanism.

From today's perspective, the project had no discernible negative impacts. In view of the sometimes challenging general conditions, caused by cumbersome bureaucracy and complex coordination processes within ECOWAS, as well as by the multi-layered implementation structures at national level, the target achievement in both phases is rated as good overall. Measures under the regional fund helped to bridge funding shortfalls in the pilot countries for a wide range of interventions to improve contraceptive supply and demand. One particular highlight is the significant improvement made even in fragile or politically unstable countries such as Burkina Faso or Guinea-Bissau.

Effectiveness rating: 2 for both phases

Efficiency

The total costs were EUR 5.01 million in the 1st phase and EUR 4.96 million in the 2nd phase, with an FC share of 98.2% and 99.9%[20] and WAHO's own share of 1.8% and 0.06% respectively. Only around EUR 91,000 of the committed counterpart contribution were spent. The remaining WAHO funds of EUR 0.69 million are in a separate account and are still available to the programme or can be used by WAHO as a reserve after the end of the programme[21]. In addition, WAHO financed office and logistics costs. The SMOs sold the contraceptives at subsidised prices and used the sales revenue to cover operational costs.

Overall, there were only minor differences from the planned budget. These were mainly due to the extensive conceptual and organisational work and the resulting delays in implementation. As a result, fewer cross-border activities were carried out in the first phase than planned. These included regional meetings, training and awareness-raising events for mobile target groups[22], which were also attended by representatives from the 10 non-pilot countries.

The international consulting costs of 4 % in the first phase and 2 % in the second phase were low compared to other bilateral and regional FC projects in the sub-sector, which had a positive impact on implementation efficiency. 15 % was spent on WAHO's administration and programme management in the 1st phase and 9 % in the 2nd phase. Drafting the national funding proposals required close coordination between government and private actors and donors. This fostered complementary implementation and efficiency.

40 % of the funds in the 1st phase were used for the procurement of SRH supplies, and 54 % in the 2nd phase. The number of products was limited to a maximum of 4 contraceptives from the 2nd phase onwards, which had a positive effect on efficiency. However, the fact that there were no group orders at regional level, only individual orders at national level, reduced efficiency. This decision was mainly politically motivated; the clear priority of the pilot countries was to enable national institutions and organisations to procure products[23]. In addition to the loss of economies of scale due to lower order volumes, this was associated with considerable additional effort for capacity building and delays. Products worth a total of EUR 4.6 million were delivered. Thereof, 45 % was used to procure condoms, 22 % for implants, 20 % for hor-

[20] Remaining FC funds were transferred to subsequent phases.

[21] According to information provided by the executing agency, a total of EUR 1.17 million is available in this account as of August 2020.

[22] Lorry drivers, fishermen, sex workers, merchants.

[23] With the exception of Guinea-Bissau, which ordered RH supplies through Burkina (SMO-PROMACO) and UNFPA.

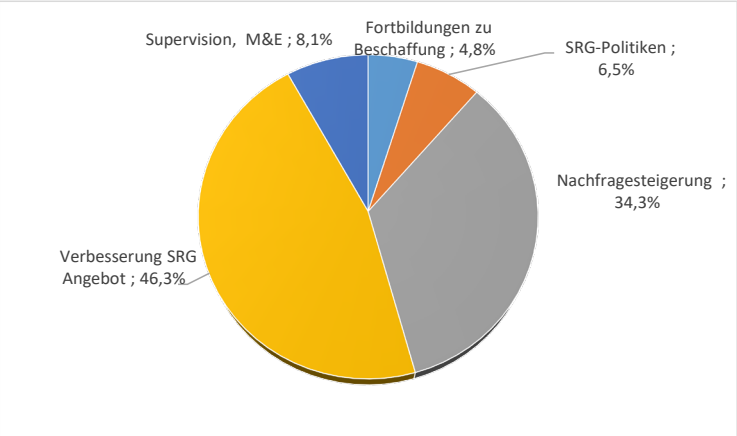
mone injections and 13 % for other SRH products[24]. As of 2013, the Pledge donor guarantee allowed implant purchases at reduced prices. On the one hand, efficiency losses were considerable in the procurement of condoms in the 1st phase, as the total costs were significantly higher than international unit prices (e.g. up to 2.7 times in 2011), mainly due to low quantities.[25] On the other hand, capacities for product procurement in compliance with international standards were strengthened at national level, making the additional costs justifiable overall.

The first five pilot countries were selected by WAHO based on political considerations and SRH indicators. For reasons of parity, all three official languages were to be represented, as well as countries with good (Ghana), medium (Benin, Burkina and Niger) or poor health indicators (Guinea-Bissau). In the subsequent phases, other pilot countries were identified primarily based on health indicators. Only pilot countries benefited from both funds of the financing mechanism on a priority basis to bridge shortfalls for SRH products and interventions. The remaining member states were involved in regional individual measures to a limited extent. In addition, the “non-pilot countries” benefited from WAHO’s lobbying for SRHR at the level of the ECOWAS ministries of health. From the perspective of allocation efficiency, countries with poor SRH indicators should have been given more support.

The allocation of funds to the pilot countries was based on a proportional adjustment of the requested amount in relation to the available funds and the size of the countries’ populations. Ghana and Burkina Faso received 37 % and 29 % respectively in the first two phases, Benin received 19 %, Niger 10 % and Guinea-Bissau 5 %. This mainly politically motivated allocation is understandable and closely linked to WAHO’s mandate, but it was not in line with the actual needs of the pilot countries. According to the interviews, the importance of the funds provided by the regional funding mechanism therefore varied considerably depending on the pilot country and implementing organisation. In Niger, for example, the project provided less than 5 % of the annual budget of the national SMOs, whereas in Guinea-Bissau it provided more than 80 %. As of 2013, 20 % of the fund’s resources for capacity improvements were allocated according to a performance-based funding principle. Formal criteria were applied on an annual basis to determine which countries received these bonuses.

Splitting the FRC into more than 160 funded individual measures reduced efficiency. Many implementation partners complained in interviews about the mainly sporadic measures. With support from the international consultant, WAHO further standardised the measures and focused on recognised “high impact practices” in subsequent phases. This process offers further potential for improving allocation efficiency. The diagram below shows that the FRC funds were predominantly used for measures to stimulate demand and improve the supply of SRH services. Starting in phase 2, the application procedure was adapted and made more efficient (fewer rounds of applications, higher individual funding).

Fig.2: How funds were used to improve capacity (2011- 2013)



[24] Condoms for women, hormone pills, collier/SDM, IUDs, kits for implants, etc.

[25] UNFPA Contraceptive Price Indicator.

From today's perspective, the timeline for the project was too ambitious. The effort to establish a regional approach, which required time-consuming coordination processes at national and regional level, was underestimated. Ongoing project support by an international consultant starting at programme outset would most likely have shortened the setup phase.

The efficiency of the 1st phase, which was originally scheduled to last 3 years, was not satisfactory. Overall, the allocation efficiency was impaired because of the focus on political considerations - and less on the needs of the pilot countries - as well as the small-scale nature of the measures, especially during the 1st phase. Production efficiency, however, improved in the 2nd phase; this was due to WAHO's low-cost implementation structure (supported by the international consultant during short-term missions), the reduction of product categories and the use of existing SMOs and their distribution channels. The overall efficiency in the 1st phase is rated satisfactory. The 2nd phase is rated as good since it was possible to implement important adjustments and recommendations and thus increase efficiency.

Efficiency rating: 3 for phase I and 2 for phase II

Impact

The objective at impact level was to contribute to improving sexual and reproductive health in the ECOWAS region. The original indicators were refined for the ex post evaluation. At the appraisal, no target values had been set, which is reasonable and justifiable given the project's modest contribution in terms of volume. For the first two phases of the project, there is no reliable data on the financing of the SRH measures of the pilot countries. For example, the national Costed Implementation Plans for family planning drawn up in subsequent phases show that the share provided by the regional financing mechanism for products (FAP) and interventions (FRC) in 2020 was 16 % in Benin, 8 % in Burkina Faso, 14 % in Ghana, 26 % in Guinea-Bissau and 20 % in Niger.

In the context of the EPE, available national target values were used for classification purposes[26]. The target achievement at impact level is summarised below:

Indicator	Status at start of programme	Ex post evaluation
(1) Decrease in birth rate among women in relationships 15-49[a] years of age	Benin 4.9 (2011) Burkina 6.2 (2010) Ghana 4.1 (2008) Guinea-B. 6.8 (2005-10) Niger 7.1 (2012)	Benin 5.7 (2017) Burkina 5.2 (2017/18) Ghana 3.8 (2019) Guinea-B. 4.5 (2015-20) Niger 6.9 (2012)
(2) New: Fertility rate of women 15-19 years of age / 1.000[a]	Benin 94 (2011) Burkina 130 (2010) Ghana 66 (2008) Guinea-B. 120 (2005-10) Niger 199 (2012)	Benin 108 (2017) Burkina 124 (2017/18) Ghana 78 (2019) Guinea-B. 105 (2015-20) Niger 206 (2012)
(3) Decrease in maternal mortality per 100,000 births[b]	Benin 480 Burkina 422 Ghana 342 Guinea-B. 827 Niger 709	Benin 397 Burkina 320 Ghana 308 Guinea-B. 667 Niger 509
(4) Reduction in HIV prevalence rate among adults[c]	Benin 1.2 % Burkina 1.3 % Ghana 1.9 %	Benin 1.0 % Burkina 0.7 % Ghana 1.7 %

[26] The pilot countries only had defined national target values for some indicators. (from FP2020 or MDGs, SDGs).

	Guinea-B. 3.9 % Niger 0.5 %	Guinea-B. 3.4 % Niger 0.2 %
(5) New: Reduction in HIV incidence rate among 15-24 year olds per 1,000 uninfected people: all (M/F)[c]	Benin 0.83 (0.56 / 1.12) Burkina 0.58 (0.46 / 0.71) Ghana 1.38 (0.58 / 2.21) Guinea-B. 2.9 (2.05 / 3.71) Niger 0.1 (0.05 / 0.14)	Benin 0.47 (0.32 / 0.63) Burkina 0.2 (0.16 / 0.24) Ghana 1,0 (0.42 / 1.62) Guinea-B. 1.53 (1.07 / 1.98) Niger 0.04 (0.03 / 0.05)

a) Data from the national surveys/DHS, b) UNICEF database, c) UNAIDS data

The birth rate of all women of childbearing age decreased in the four pilot countries, with the exception of Benin, and most markedly in Burkina Faso and Guinea-Bissau. However, this trend does not affect all age groups equally. In Benin and Ghana, the fertility of young women has increased in recent years. Only Burkina Faso had set a target for this indicator under FP2020. The aim was for the birth rate to fall to 4.7 children per woman by 2020. Although no current data is available, given the marked increase in contraceptive prevalence rates (see Effectiveness), it is likely that this objective has been achieved.

Maternal mortality declined in all countries, most significantly in Niger (-30 %) and least in Ghana (-18 %), which already had the lowest rate at the start of the programme. However, recent data from Benin also shows that maternal mortality among young women aged 15-19 has been on the rise again for 10 years. Their risk of dying as a result of pregnancy has increased disproportionately (+63 %) compared to women of all ages (+5 %).[27] [28] All pilot countries had targeted a 75 % reduction in the respective maternal mortality rate for this MDG indicator by 2015, but it was not possible to achieve this.

HIV prevalence has decreased in all countries since the programme began, with the largest decreases in Niger (-60 %) and Burkina Faso (-47 %) and the smallest in Ghana (-23 %). The MDG goal of reversing the trend of HIV infections was achieved in all pilot countries. The additional indicator of HIV incidence, which shows new infections among adolescents and young people, has fallen significantly since the start of the programme; most sharply in Burkina (-66 %) and Niger (-60 %), and least in Ghana (-28 %). However, the figures also underscore the feminisation of the HIV epidemic in the pilot countries. Young women in Burkina are infected with HIV 1.5 times as often compared to young men, and in Ghana even up to 3.8 times as often.

The project's contribution to the increased prioritisation of family planning resulting from WAHO's structurally effective work at the national and regional level deserves a particular mention. Many of the stakeholders interviewed attributed a "catalytic effect" to the FC project. Thanks to stronger institutions and successful programme implementation, WAHO's reputation as an effective organisation for regional health programmes has improved. This has encouraged the diversification of interventions and the acquisition of new donor funds by WAHO, which, in turn, has significantly increased the scale and reach of regional mechanisms established under FC interventions since 2018. In 2021, eleven of the fifteen countries benefit from the two regional funding mechanisms, which are now co-financed by the Bill & Melinda Gates Foundation, AFD and the Netherlands. In this respect, the FC project served as a model and can be recommended for replication.

The project measures bridged important financing shortfalls for SRH products and services in the five pilot countries on the one hand, and increased demand for SRH products among the target population on the other. This has prevented unwanted pregnancies, risky abortions and HIV infection. In view of the overwhelmingly positive trends in the indicators, it can be assumed that the regional programme contributed to the developmental impacts in terms of sexual and reproductive health. In addition, the project had a positive impact on population dynamics in the ECOWAS region. Firstly, through the policy dialogue on SRHR

[27] DHS Benin 2017/2018 - reference period since the last maternal mortality survey in 2006.

[28] In Benin, a wide range of factors affect relatively small improvements in SRHR. These include: lack of political commitment to FP, unfavourable sector policy framework, widespread pro-natalist tendencies, strong influence of the Catholic church, gender and social norms as barriers especially for young people, ignorance and rejection of modern FP methods and regional differences for access to information & services.

and family planning promoted by WAHO at regional and national levels. Secondly, the supported measures contributed to the decline in the birth rate and thus contributed to the demographic dividend. The first two phases also laid the foundation for the creation of structures and a broad project impact, which is reflected in the success of the subsequent phases, including the involvement of other donors. The overarching developmental impacts thus fully meet expectations, which is why both phases have been rated as good.

Impact rating: 2 for both phases

Sustainability

Although family planning has become more important overall in the ECOWAS region, it does not have the same status as the response to HIV. Improved access to SRH products and services is increasingly embedded in national strategic plans and budgeted FP action plans. However, there is still a high degree of dependence on external funding. Over 90 % of the interventions and products of the currently supported pilot countries are donor funded. With increasing demand for FP services and products, the funding mechanism will still be highly dependent on donors in the medium term, which was to be expected. Even with a growing national willingness to co-finance SRH products and services, donor funds will continue to be needed in the region to bridge funding shortfalls. In addition, the political and economic conditions in ECOWAS states have deteriorated, which could be compounded by the current Covid-19 pandemic. To improve sustainability, the final review of the first two phases already recommended WAHO, with the support of the international consultant, to develop a long-term concept for embedding the regional fund.

The institutional sustainability of the executing agency is rated as good. WAHO's total budget has increased from USD 5.5 million in 2006 to EUR 26.3 million in 2012[29]. The ECOWAS share of the budget increased from 27 % to 81 % during this period. Since the programme began, WAHO has increased its technical and programming capacities and consolidated its role as a competent lobbyist for SRH issues. Support for the member countries in drawing up national strategic plans and embedding the availability of SRH supplies at institutional level also has a positive effect on the sustainability of the project.

Interviewees unanimously stressed the benefits of improved coordination of private and public actors and the sustainable strengthening of health systems to plan, implement and mobilise resources for SRH programmes. Applications and reports consolidated by the respective ministries of health increased transparency and accountability at the national level between the ministries of health and the respective implementing non-governmental organisations. Training enabled national procurement platforms and SMOs to carry out international purchases independently. Representatives of national SMOs praised the networking and the resulting dialogue at regional level.

The regional SMO network initiated by the project is formally established by law, but is not operational due to a lack of secure funding. In addition, the sustainability of various national social marketing programmes is at risk in the medium term. On the one hand, this is due to declining donor funding for the approach, and on the other hand, to strong competition from international, regionally active SMOs whose intervention strategies are more efficient and innovative. To this extent, it is possible that, in the medium term, new implementation partners will have to be identified in some pilot countries and appropriate training provided by the project.

The sustainability of the developmental impact of the project is at risk in some cases. The effects of information and awareness-raising campaigns are generally limited to a specific period of time. The increased fertility rates in some pilot countries, especially among young women, raise questions which WAHO should address in the regional policy dialogue and consistently pursue in the further development of the regional programme. In summary, the sustainability of the project for both phases is rated as satisfactory.

Sustainability rating: 3 for both phases

[29] More current figures are not available.

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).