KFW

Ex post evaluation – Caribbean Community

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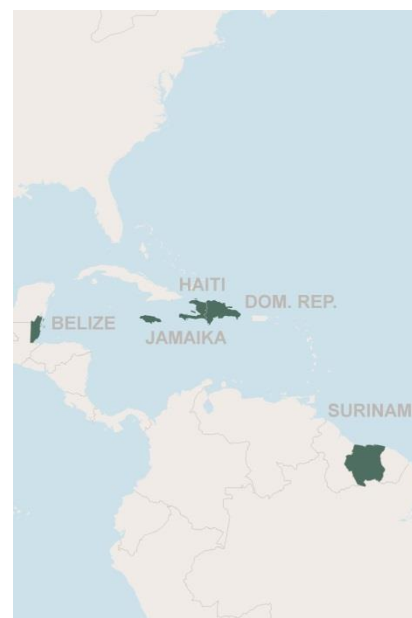
Sector: STD control including HIV/AIDS (13040)
Project: HIV/AIDS prevention and promotion of reproductive health in the Caribbean (2006 66 404 (Phase II)*, 2008 65 436 (Phase III), 2012 66 907 (Phase IV)*
Implementing agency: Caribbean Community (CARICOM)



Ex post evaluation report: 2017

		Phases II-IV (Planned)	Phases II-VI (Actual)
Investment costs (total)	EUR million	31.8	73.0
Sales revenues	EUR million	2.4	0.6
Counterpart contribution	EUR million	1.0	1.0
Funding	EUR million	28.4	71.4
of which BMZ budget funds	EUR million	21.4	21.4

*) Random sample 2017

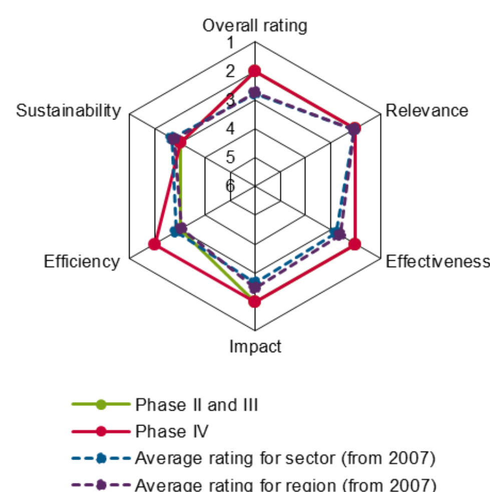
Summary: The aim was to contain the strong spread of the HIV/AIDS epidemic in the Caribbean and improve the target groups' sexual and reproductive health (SRH) through improved access to high-quality and affordable condoms and contraceptives, along with sustainable behavioural changes in contraception and family planning. Additionally, widespread sharing of knowledge about the epidemic, transmission risks and prevention options was intended to reduce stigmatisation and social exclusion of those infected with HIV and AIDS. The Financial Cooperation (FC) funds were used to procure and sell condoms and hormonal contraceptives, to fund approaches to strengthen women's rights and positions in society in relation to SRH, to protect against unwanted pregnancies (family planning), and to fund accompanying studies and consulting services. HIV/AIDS presents a regional problem in the Caribbean as a result of the strong intra-regional migration flows, which requires a supranational prevention strategy. The Caribbean Community was therefore selected as the programme's implementing agency, and delegated the implementation of the programme to the Pan-Caribbean Partnership Against HIV/AIDS (PANCAP), which in turn contracted social marketing agencies for implementation.

Development objectives: The regional project was intended to contribute generally to improving sexual and reproductive health and specifically to containing the HIV/AIDS epidemic and the transfer of other sexually transmitted diseases (impact). This was to be accomplished by (1) the increased use of contraceptives, and (2) a change in the target group's attitudes and conduct regarding family planning and reproductive health (outcome).

Target group: The sexually active and poverty-afflicted population in the programme region, especially high-risk HIV groups.

Overall rating: 2 (all phases)

Rationale: In the first regional project in the health sector, the target group-specific and region-specific strategy had positive effects, as well as being one of the few projects in the region focusing on HIV/AIDS prevention. These impacts were achieved both in meeting the development policy objectives and in terms of long-term behavioural changes in the high-risk groups. The integration of the SRH approach contributed to making the FC project crucially important in the Caribbean.



Highlights: The complex FC project was distinct in featuring a variety of proven but innovative approaches, such as social marketing aiming at developing the general condom market, multimedia information campaigns and the use of social media to reach high-risk groups and young people in an environment marked by violence, along with auxiliary research and regional exchanges of experience. Challenges included the patchwork nature of the Caribbean (a region with relatively high transaction costs shaped by its linguistic diversity and fragmentation) and ensuring the HIV/AIDS prevention measures' financial sustainability.

Rating according to DAC criteria

Overall rating: 2 (all phases)

As the three phases are serial measures and the impacts cannot be isolated, all the phases are evaluated together, with separate ratings according to the DAC criteria where necessary. The final inspection (December 2015) was carried out jointly for Phases II, III and IV.

Breakdown of total costs

		Phase II (Planned)	Phase II (Actual)	Phase III (Planned)	Phase III (Actual)	Phase IV (Planned)	Phase IV (Actual)
Investment costs	EUR million	18.1	8.6	5.3	55.5	8.4	8.8
Sales revenues	EUR million	2.4	0.6	0	0	0	0
Counterpart contribution	EUR million	0.3	0.3	0.3	0.3	0.4	0.4
Funding*	EUR million	15.4	7.7	5.0	55.2	8.0	8.5
of which BMZ budget funds**	EUR million	8.4	7.7	5.0	5.2	8.0	8.5

* The donors' contributions for advertising campaigns (refer to "Efficiency" section) were predominantly assigned to Phase 3. At the PA (Phase II), co-financing of EUR 7 million was envisaged.

** Phase I residual funds of around EUR 0.4 million used for Phase II, and Phase II/III residual funds of around EUR 0.5 million used for Phase IV.

Relevance

Despite the members of the Caribbean Community (CARICOM) declaring combating HIV/AIDS a regional priority in 2001, a generalised HIV epidemic affected most Caribbean countries as of the project appraisal (PA) for Phases II/III in 2007. This region was the second most heavily HIV/AIDS-afflicted in the world after Sub-Saharan Africa, with a prevalence of 1.2%. This included considerable differences in the prevalence rates between countries and population groups. At 3.6%, Haiti had the highest average prevalence rate, followed by the Bahamas (3.1%), Belize and Jamaica (1.9%) and the Dominican Republic (1.7%). In total, close to 261,000 infected people lived in the region in 2007, 70% of them on the island of Hispaniola (Haiti and DR), and close to 27,000 new people became infected each year. HIV/AIDS had been the main cause of death among the 25-44 age group (19,000 deaths in 2007) and around a third of those infected with HIV were between 15 and 24 years old. The proportion of HIV-infected women had risen drastically in the years before the PA from 24% (1990) to half of all those infected by 2007. Consequently, the risk of mother-to-child transmissions of the HIV virus also increased. The HIV virus was transmitted at a rate of 60-80% in unprotected heterosexual intercourse (predominantly with female commercial sex workers – CSWs), and at 10-15% in unprotected homosexual intercourse (predominantly between men – MSM). For this reason, the high-risk groups specified by country – CSWs, MSM and at-risk youth – were accurately identified as target groups (Country Progress Reports, UNAIDS 2007-2016, WHO 2007-2016).

The chain of effects rests on sound logic. The spread of knowledge about HIV prevention, responsible sexual activity and condom use – in connection with an improved supply of high-quality, inexpensive condoms[1] – is to help reduce risky behaviour. This, in turn, is to lower the number of new HIV infections and the transmission of other sexually transmitted diseases. A gap has existed between knowledge concerning the HIV risk and actual behavioural changes as a result of deep stigmatisation and discrimination against people infected with HIV in the population, at health facilities and at work, as well as at-risk groups lacking access to quality but affordable sexual and reproductive health (SRH) services. By programme design, this gap was intended to be closed with both anti-stigmatisation campaigns and a component to

[1] These were subsidised condoms sold through NGOs, whose prices were below those in the commercial sector. Procurement of these condoms was originally intended to be funded from FC funds. However, USAID provided the condoms in the course of the FC project. The FC supported the sale of the condoms.

strengthen women's rights and positions in society. HIV prevention was not to be addressed by securing access to contraceptives alone, but also through change in the societal approach to HIV/AIDS and via links to SRH. The teenage birth figures show the relevance of this added remit. Though many Caribbean countries had a comparatively high contraceptive prevalence rate, 40% of all women in Jamaica already had at least one child by the time they turned twenty. Additionally, Haiti was one of the few countries outside Sub-Saharan Africa with maternal mortality defined as high.

Given the historic and economic links between the great number of Caribbean countries, alongside the strong intra-regional migration flows, HIV/AIDS poses a regional problem requiring a supra-national prevention strategy. Supporting CARICOM as part of the regional approach, the Financial Cooperation (FC) measure had potential to contribute to enhancing collective health policy, strengthening regional cooperation and creating synergy in the implementation and proliferation of best practices. Most programme countries were no longer part of the DAC recipient list and could therefore only participate in the FC project via their affiliation to PANCAP. The selection of the regional approach was accordingly convincing.

The project was consistent with the Millennium Development Goals (combating HIV/AIDS, empowering women, reducing child mortality and improving the health of pregnant women and mothers; Goals 3-6) and the current sustainable development goals ("ensure healthy lives and promote well-being for all at all ages"; Goal 3). Health was a priority area of the development cooperation agreed at the time of the PA and was in line with the regional AIDS strategy's objectives (Caribbean Regional Strategic Framework 2008-2012, 2014-2018). At the PA, the majority of donors and national programmes concentrated on AIDS treatment, meaning that the FC project was one of the few measures focusing on HIV/AIDS prevention.

Relevance rating: 2 (all phases)

Effectiveness

The programme objectives (POs) at the PA were to (1) improve the state of knowledge, attitudes and behaviour around effective prevention, and (2) improve the target group's supply of low-cost, high-quality contraceptives. These objectives were adjusted within the scope of the ex post evaluation to meet contemporary state-of-the-art standards (use of service) and to delineate the SRH components. They are now to (1) increase use of contraceptives, and (2) change the target group's attitudes and conduct regarding family planning and reproductive health. The indicators were adjusted to a small extent and standardised for across the three phases. The defined module objective indicators are fundamentally suitable for rating the FC project's success. The indicator for development of the condom market is in fact an output measurement, but is useful to collect as a proxy indicator, making it reasonable to include. The achievement of the indicators[2] can be summarised as follows:

Indicator (1)	PA status	Target value	Ex post evaluation
Increase in the proportion of respondents in the KAP (knowledge, attitude, practices) studies indicating consistent condom use (and, in turn, changes in terms of their risk-taking behaviour) in %: Prostitutes (with clients) - Eastern Caribbean countries - Belize - Haiti - DR - Suriname	89% (2008) 60% (2007) 46% (2008) 59% (2008) 96% (2010)	+5% increase +5% +10% increase	95% (2012) 81% (2012) 73.9% (2015) 76% (2013) 91% (2012)

[2] The indicators cannot be broken down individually for each country, as different target groups were addressed with different measures in each country and data from the IBBS (integrated behavioural and biological survey), TRaC (tracking results continuously study) and DHS (domestic health surveys) were not available for every country.

MSM			
- DR	70% (2007)	+3%	76% (2013)
- Haiti	36.5% (2011)	+3%	28.8% (2015)
- St. Lucia	60% (2010)	+3%	48% (2012)
Sexually active young people			
- DR (women/men)	47%/71% ('07)	+10%	48%/72% (2013)
- Haiti	55% (2012)	+10%	43% (2015)
- St. Lucia	81% (2012)	+10%	62% (2015)
Indicator (2)	**Target value (nominal)**	**Ex post evaluation**	
Increase in the distribution of condoms and other contraceptives in the entire market (total market approach[3])	Target PA: 31.5 million social marketing (SM) condoms sold	The condom market has grown in all the countries since 2007, with the largest markets existing in Haiti and the DR. Altogether, 43.5 million SM condoms were sold. TMA (2015): Haiti / DR Public sector: 67%* / 20% SM sector: 14% / 55% Private sector: 19% / 25% *Abundance of free condoms after earthquake in 2010.	

In terms of achieving the indicator (1) target value, the FC project faced the challenges posed by the Caribbean's geographical, linguistic and political fragmentation and the impacts of information, education and communication measures, which are scientifically proven to be limited in actually contributing to behavioural changes. Severe stigma associated with HIV-positive people, high promiscuity and the disadvantages faced by women also had a stunting effect, though were partly addressed by the programme design. The high-risk male group – frequently in environments marked by violence – was difficult to reach and MSM often keep in self-contained groups that are rarely accessible. For instance, 64% of MSM in Jamaica in 2012 also had heterosexual sex, meaning that those infected could also contribute to spreading the HIV virus outside their group. Yet overall, with regard to achieving objective (1), we would note that behaviour changes towards a more risk-conscious approach could be recorded in particular among prostitutes and young people in all countries as a consequence of the FC project.

Mobile and stationary health facilities were able to modernise their provision of SRH services, boost their available capacity and introduce new testing and treatment methods via targeted, FC-funded consultancy measures and investment grants. Many of the clinics and facilities of the International Planned Parenthood Federation (IPPF) operated with vouchers, which is how the FC project organised the funding of individual services, such as pregnancy examinations, HIV tests, cervical and breast cancer screenings, and check-ups for sexually transmitted diseases. In total, 70% of the vouchers issued in the DR were redeemed. Poorer sections of the population and CSWs, who had no access to reliable public services and could not afford hormonal contraceptives, were the target group. These contraceptives were sold at subsidised prices in the health facilities. HIV prevention and family planning have been constantly integrated and provided in this area. These measures contributed to target achievement and made it possible to reach target groups that previously had no information about HIV transmission and could have an HIV test performed for the first time.

The access indicator defined during the PA ("increase in high-risk groups' access to condoms and other contraceptives") does not measure the target group's use of services that are performed. Consequently,

[3] For example, FC-financed contraceptive brands and all contraceptives sold or distributed for free by private, state or non-governmental organisations.

this was only consulted as an auxiliary indicator during the evaluation of target achievement. Note that condom availability was broadened through support and expansion of non-traditional points of sale (kiosks, motels), the SM and the development of context-specific sales models. The proportion of CSWs who have contraceptives available within 10 minutes has risen in almost all programme countries in recent years. The same is true of the proportion of young people and MSM in the Eastern Caribbean who have a condom available when needed. This altogether positive development highlights the substantial growth in condom availability. The FC project was able for the first time to reach at-risk groups that do not trust the governmental structures, cannot afford public or private health services, or are too far removed from these. Prolific use of social media (Facebook, Twitter and more) expanded the coverage of the FC project's messaging and reached high-risk groups, including in environments marked by violence. Nonetheless, only 32.5% of young people surveyed in Belize and 26.5% in Suriname (90% condom availability) knew properly how to use this. In Haiti and Belize, the risky behaviour of young people in recent years has also increased rather than decreased. This may correlate with the better care and antiretroviral treatment of infected patients, which is lowering the risk of dying of HIV/AIDS (impact criterion). Yet in any case, the actual comparability of the figures must be treated with caution due to a different random sampling procedure in KAP studies and some inconsistent results.

In addition to condom availability and affordability, prevention and information remain important activities in the region. Stigmatisation and discrimination against HIV/AIDS sufferers have also noticeably diminished in the overall population. In summary, considering that the target values have almost entirely been met, we accordingly rate the programme measures' effectiveness as good.

Effectiveness rating: 2 (all phases)

Efficiency

Phases II and III were concluded on schedule on 31 December 2012 and 2013, respectively (Phase III was an extension of the overall lead time). Phase IV started on 1 April 2013 and at the partner's request was concluded on 31 December 2015 instead of 30 September 2015 as originally planned. During the PA, the total cost was estimated at EUR 31.8 million, of which EUR 23.4 million went to regional and content expansion in Phases II and III, and EUR 8.4 million to the consolidation phase (Phase IV). Costs increased to a certain degree due to the extended lead time and accompanying need for additional support to boost sustainability. Additionally, expensive advertising and awareness campaigns, which other donors co-funded, caused increased costs. This meant that the total cost rose to around EUR 73 million. However, this increase should not be interpreted as a cost overrun but as an expansion of activities. The low revenues from FC-financed products (around EUR 600k) were used to fund project measures. We consider the total cost within this project – innovative and characterised by difficult geographical realities and associated logistical challenges as it was – to be acceptable considering the variety of measures successfully implemented.

A local specialist was financed from FC funds with the aim of administratively supporting the regional organisation PANCAP because of its restricted execution capacities. In addition, a regional consultant (options) was responsible in Phases II and III for implementing, controlling and supervising the activities performed by NGOs (social marketing agencies (SMAs), along with family planning organisations) in the individual countries. This concept was reasonable as of the project appraisal and proved itself suitable with regard to PANCAP's execution limitations, as project implementing agency functions were largely delegated to the consultant. This allowed the FC project to generally proceed properly in terms of technical professionalism, finances and timing. The diverse range of SMAs and family planning organisations separately commissioned within the regional consultant's structure entailed enormous effort for the FC in terms of allocation and control, since the regional consultant had little delegated decision-making power. This structure also involved numerous interfaces, overlapping responsibilities and duplicate work in reporting and conducting studies. There was an important and positive change to counter these losses of efficiency in Phase IV, which was performed to reinforce the results achieved and strengthen sustainability. There was no collaboration with a regional consultant who in turn commissioned various NGOs, as in the previous phases. Instead, a general contractor was used and was responsible for implementation on both local and regional levels, assigning fundamental elements of execution to local sub-contractors within the scope of its contract. Award of contracts was only subsidised with FC funds from an acceptable minimum scope onwards. Pooling activities in a general contractor's hands increased flexibility and contributed to

cutting transaction costs. Consequently, we assess the execution structure of Phase IV as being more efficient.

Overall, we would emphasise that the regional approach has contributed to gains in efficiency, considering the patchwork nature of countries in the Caribbean, a fundamentally cost-intensive region due to its linguistic diversity and the specific characteristics of each target sub-group. The local NGO offices benefited from regular sharing of proven approaches and joint campaigns were executed successfully, promoted efficiently through social media. The Consultative Monitoring Group's annual meeting, which included PANCAP, implementing organisations, donors and interested partners, was an important forum for regional exchange and international approach planning. On the other hand, aside from the FC project, the parties operating in the field of HIV/AIDS work had fairly weak practical coordination and exchange on both regional and national levels due to a lack of national leadership.

The FC-financed SM condoms were primarily distributed in the DR and Haiti, which have a segmented condom market with no overlap between these market segments due to differing brand images and the price differences between SM and commercial condoms. The sales structure was adjusted several times during the programme execution and efficiency-related improvements were implemented (better coordination, focus on hot zones, cutting out intermediaries without added value, use of social networks). The decisions were supported by market and target group studies that were financed via the FC project. The appropriateness of the pricing was also reviewed at regular intervals via surveys on the target group's willingness to pay. There are no indications that subsidies were excessive. The FC-financed "Cool" SM condom was introduced in the Eastern Caribbean, though it was not followed up on due to SMA personnel shortages and changes in priority regarding family planning and hormonal contraceptives. In addition, the Eastern Caribbean condom market demonstrated high market maturity with a strong commercial sector, meaning that the price difference with the SM condom would have been too small to directly target another group of consumers without taking customers from the private sector. This was recognised and product advertising was relinquished accordingly in line with the total market approach. Instead, the successful "Got it? Get it?" general-purpose campaign was carried out regionally. The efficiency therefore was not rated based on the appropriateness of contraceptive costs[4], because the condom market in the countries was distinct, and not only sales of SM condoms were encouraged but also a rise in overall demand.

The FC project was implemented in parallel to the national AIDS programmes. The measures were not integrated into the public health system. The concentration on the non-governmental sector was planned this way by design and should be rated as positive in terms of efficiency, as it allowed measures to be executed quickly and for the long-term via NGOs without being subject to the political will of changing governments. The NGOs' contacts with health ministries, national AIDS programmes and AIDS coordination committees guaranteed exchange and some collaborative work on campaigns. Nevertheless, the national health systems themselves did not take over the tasks and activities implemented by the NGOs, nor is this foreseeable in the near future (see "Sustainability" criterion).

Efficiency rating: 3 (Phases II and III) and 2 (Phase IV)

Impact

The project's development objective was to contribute generally to improving SRH and specifically to containing the HIV/AIDS epidemic and the transfer of other sexually transmitted diseases. The PA did not use development objective indicators for Phases II/III; this does not meet contemporary state-of-the-art standards. The absence of an indicator to measure the reduction in sexually transmitted diseases is justified owing to a lack of available data. We can deduce from the following indicators (added as part of the ex post evaluation) whether the situation is moving in the right direction:

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[4] Generally carried out using a method known as the Chapman Index, where the respective target group is to be able to obtain the contraceptives they need for a year (couple-year protection) with no more than 1% of per capita income.

Indicator	Status PA (2007)	Ex post evaluation*
(1) Reduction of the HIV prevalence rate among 15-24 year olds in %**	DR: 1.7 Haiti: 3.6 Belize: 1.9 Jamaica: 1.9 Suriname: 1.2 Trinidad: 1.2	DR: 1.0 (2015) Haiti: 1.7 (2015) Belize: 1.5 (2015) Jamaica: 1.6 (2015) Suriname: 1.1 (2015) Trinidad: 1.2 (2015)
(2) Growth in the contraceptive prevalence rate	DR: 72.9 (DHS, 2007) Haiti: 32 (DHS, 2005) Belize: 53 (UNAIDS, 2005-2009) Jamaica: 68 (UNAIDS, 2005-2009) Suriname: 48.5 (MICS**, 2006)	DR: 71.9 (DHS, 2013) Haiti: 34.5 (DHS, 2012) Belize: 60 (MICS, 2011) Jamaica: - Suriname: 50.6 (MICS, 2011)
(3) Reduction of the HIV incidence rate among 15-49 year olds (absolute and per 1,000 non-infected people, respectively)	DR: 4,200 (2005), 2,300 (2010) Haiti: 11,000 (2005), 3,700 (2010) Belize: <500 (2005), <200 (2010) Jamaica: 2,000 (2005), 1,600 (2010) Suriname: <500 (2005), <200 (2010) Trinidad: <1,000 (2005), <500 (2010)	DR: 2,000; 0.36 (2015) Haiti: 1,500; 0.21 (2015) Belize: <200; 0.82 (2015) Jamaica: 1,700; 1.07 (2015) Suriname: <200; 0.62 (2015) Trinidad: <500; 0.52 (2015)

*The latest available official data was used in each case

**MICS: Multiple Indicator Cluster Surveys (http://mics.unicef.org/)

Development objective indicator (1) is used as an internationally accepted approximation of how the number of people infected has changed (prevalence) among the 15-24 age group. However, the prevalence rates' informative value is limited concerning the epidemic's development, because they only measure the total number of people infected with HIV in this age group. Numerous factors affect HIV prevalence rates. The rate stops falling when successful treatment of HIV patients extends their lifespans (70% growth in antiretroviral treatment (ART) rates between 2001 and 2010; almost 50% drop in AIDS-related deaths between 2000 and 2014). At the same time, the rate increases due to early detection of the HIV virus with growing test numbers (part of the project). Additionally, the collection methods are difficult to compare over time and among population groups.

Indicator (3) was extended to enable measurement of new infection numbers and assessment of the containment's time aspect. According to UNAIDS, the Caribbean has managed to record one of the strongest reductions compared with all other regions of the world, with the number of new HIV infections in the 15-49 age group falling by over 50% (2001: 25,000; 2012: 12,000). We can assume that the FC project contributed to the encouraging trend in the HIV incidence rate, as the German FC was one of the most important donors in the HIV/AIDS prevention field.

We can assume from the positive trends across all indicators and the sound chain of effects that the programme contributed to achieving the developmental impact.

Impact rating: 2 (all phases)

Sustainability

Public expenditures in this area have increased in almost all programme countries since 2007, promoted by regional strategies and advocacy activities by PANCAP and the need to boost commitment in the fight against HIV/AIDS. Meanwhile, external funds have fallen considerably during the same period. However, the majority of HIV/AIDS expenditure (56.3%) still continues to be donor-funded (mainly by the World Bank, USAID and GFATM), followed by public (39.2%) and private funds (4%). The differences between the individual Caribbean countries here are immense, correlating with the countries' varied levels of economic strength. The proportion of external financing is 99% in Haiti and a mere 4% in Trinidad and Tobago. In this area, the governments concentrate on the provision of ART drugs, which are supplied free of

charge via the public sector, as well as sometimes by the private sector and civil society. However, restricted opening times, long journeys and waiting times, and poorly trained and frequently discriminatory healthcare personnel continue to create barriers to access. These were partially removed with the FC-supported mobile and stationary clinics that today are still in operation and well attended. The clinics are incorporated in the national health system, but for the most part do not receive any government support and are financed via IPPF structures, private and other donors. The sustainability of many measures was assured in Phase IV by training and educating personnel (most of whom still work in the supported clinics), improving the clinics' equipment, and disseminating informative material (which continues to be used).

PANCAP has proved itself as a highly committed partner with strong access to the national governments, succeeding in addressing the challenges associated with HIV/AIDS on a political level, and coordinating and accelerating the efforts to control the epidemic. The FC project's sustainability benefited from this. By strengthening PANCAP, the FC project promoted the intensification of a joint health policy and reinforcement of the regional cooperation that primarily benefited the smaller countries. PANCAP supported these in formulating national HIV/AIDS policies, but also induced governments to assume as large a portion as possible of the previously externally financed measures (financing free condoms, offering HIV tests, running anti-discrimination campaigns). PANCAP is more robustly supported by CARICOM today, meaning that the salaries for most staff will be secure in the future and no longer donor-dependent.

Discrimination and stigmatisation have decreased over the course of recent years and with a generation that has gained awareness, including via the Internet and social media. Yet 11 Caribbean countries still have discriminatory legislation to this day (in some cases also related to HIV-infected people) with prison sentences for homosexuality. Furthermore, the Catholic conservative imprint on the region, in which the church holds influence over policy, inhibits efforts to improve sexual education in schools, publicly-funded family planning and non-discriminatory approaches to HIV-infected people and at-risk groups. However, a change is also becoming apparent here between the conflicting priorities of the "AIDS Church". Faith leaders from member countries now sit on the board of PANCAP and have been discussing HIV strategies, with an increasing number of churches committing to educational work against HIV/AIDS and participating in civil society networks to combat HIV.

As the programme has concluded, the German Federal Ministry for Economic Cooperation and Development (BMZ) has withdrawn from healthcare as a priority area. Combating HIV/AIDS remains a priority for the Caribbean countries, at least on paper. In 2015, the countries agreed on new regional objectives for prevention at their HIV Forum, such as decreasing HIV incidence by 75% by 2020, ensuring 90% of those in high-risk groups have access to HIV prevention measures, and repealing discriminatory legislation concerning HIV/AIDS sufferers. On the other hand, the situation is unclear regarding ongoing funding of prevention measures that are indispensable for sustainable behavioural change among a changing and growing target group. The FC project was one of the few prevention projects in the region and so far, it has been questionable whether the governments will earmark sufficient funds to this end in the future.

In summary, we classify the project's sustainability – since its completion and looking ahead – as satisfactory.

Sustainability rating: 3 (all phases)

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Notes on the methods used to evaluate project success (project rating)

Projects (and programmes) are evaluated on a six-point scale, the criteria being **relevance, effectiveness, efficiency** and **overarching developmental impact**. The ratings are also used to arrive at a **final assessment** of a project's overall developmental efficacy. The scale is as follows:

Level 1	Very good result that clearly exceeds expectations
Level 2	Good result, fully in line with expectations and without any significant shortcomings
Level 3	Satisfactory result – project falls short of expectations but the positive results dominate
Level 4	Unsatisfactory result – significantly below expectations, with negative results dominating despite discernible positive results
Level 5	Clearly inadequate result – despite some positive partial results, the negative results clearly dominate
Level 6	The project has no impact or the situation has actually deteriorated

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).