Ex post evaluation - Azerbaijan, Georgia, Armenia

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Sector: 12250 Infectious disease control (according to current classification 12263 Tuberculosis control)
Project: Supraregional Tuberculosis Control Programme II in (i) Armenia (BMZ No. 2007 66 196)*, in (ii) Azerbaijan (BMZ No. 2007 66 212) and in (iii) Georgia (BMZ No. 2007 66 204)*
Implementing agency: (i) Ministry of Health Armenia, (ii) Ministry of Health Azerbaijan, (iii) Ministry of Labour, Health and Social Affairs Georgia

Ex post evaluation report: 2019

All figures in EUR million	(i) (Planned)	(i) (Actual)	(ii) (Planned)	(ii) (Actual)	(iii) (Planned)	(iii) (Actual)
Investment costs (total)	1.00	1.22	1.65	1.72	1.35	1.66
Counterpart contribution	-	-	-	-	-	0.26
Funding	1.00	1.22	1.65	1.72	1.35	1.40
of which budget funds (BMZ)	1.00	1.22	1.65	1.72	1.35	1.40

*) Random sample 2017

Summary: The three projects that make up the regional tuberculosis (TB) control programme in the Caucasus represent a continuation or addition to the first phase of the "Supraregional Tuberculosis Control Programme". The aim is for previously funded structures such as the national reference laboratory (NRL) and culture laboratories to be consolidated and the countries supported in the ongoing fight against TB. Effective interruption of the chain of infection and successful containment of TB diseases can only be achieved if, in addition to simple TB, multi-resistant tuberculosis (MDR-TB) is diagnosed early and treated with effective second-line drugs according to the DOTS Plus strategy (Directly Observed Treatment, short course). This requires the development of the necessary diagnostic and treatment capacities for MDR patients, which were co-financed by the projects, among others.
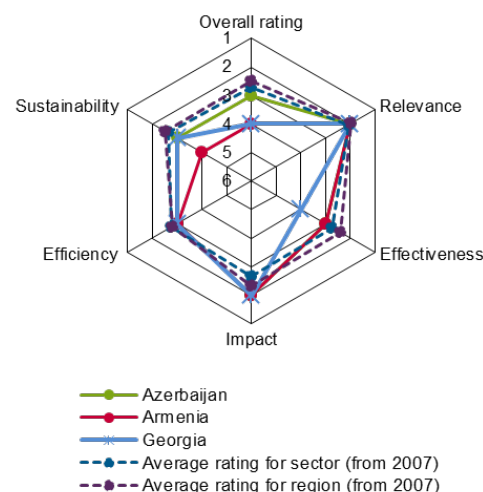
Objectives: The objective of the Supraregional Tuberculosis Control Programme was to contribute to improving the diagnosis and treatment of the various forms of TB, including MDR-TB (outcome). The overarching development objective (impact) was to help break the chain of TB infection. The programme was thus intended to support the Millennium Development Goal no. 6 "Combating HIV/AIDS, malaria and other diseases".

Target group: The target group comprised the entire population living in the programme region (16 million inhabitants). Since the risk of contracting TB depends to a large extent on social living conditions, it was assumed at project appraisal that the poor would benefit most from the projects.

Overall rating: 3 (Azerbaijan), 4 (Armenia, Georgia)

Rationale: Overall, the objectives of the programme were only partially achieved. The NRL in Tbilisi has still not opened, which has led, among other things, to an unsatisfactory assessment of the effectiveness of the project and to a rating of 4 for the project as a whole. The withdrawal of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) poses a high risk to the sustainability of the measures in the medium term. While Georgia and Azerbaijan are moving forward with the outpatient approach to TB control, which is appropriate given the large size of the countries, this is not yet the case in Armenia. In Armenia, for example, the assessment of sustainability is downgraded by the fact that the country continues to rely solely on inpatient structures, the private sector plays no relevant role and there is hardly any dialogue with neighbouring countries on the migration of TB-infected persons. The high mobility of the people in this region represents a challenge for TB control that can only be solved collectively. Accordingly, the project received an unsatisfactory rating in terms of sustainability (and thus also as an overall rating).

Highlights: -

Legend:
- Azerbaijan
- Armenia
- Georgia
- Average rating for sector (from 2007)
- Average rating for region (from 2007)

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Rating according to DAC criteria

Overall rating: 3 (Azerbaijan), 4 (Armenia, Georgia)

As the three projects under the Caucasus Initiative were appraised, committed and implemented as a supraregional programme, the three projects were also evaluated together. Wherever possible, however, the projects are assessed separately based on the DAC criteria.

Ratings:

Relevance	2 (all projects)
Effectiveness	Azerbaijan 3, Armenia 3, Georgia 4
Efficiency	3 (all projects)
Impact	2 (all projects)
Sustainability	Azerbaijan 3, Armenia 4, Georgia 3

General conditions and classification of the project

The three projects evaluated here build on the previous phases evaluated in 2013 in Georgia, Armenia and Azerbaijan (BMZ No. 2000 66 373, 2002 65 462, 2002 65 470, 2002 65 488). The FC measures at the time included the financing and procurement of tuberculosis drugs, laboratory equipment, disposables, X-ray machines and vehicles, the construction and rehabilitation of laboratories, resistance studies and educational campaigns as well as technical support in the areas of policy development, case detection and management, awareness raising and regional cooperation. The projects were given a rating of 2 or 3 (Armenia) because the foundations were laid for improved diagnosis and treatment for effective tuberculosis control in the Caucasus. Structural problems, however, inhibited even greater impacts. In Azerbaijan and Armenia, misguided financial incentives prevented more effective and efficient treatment. The national tuberculosis control programmes still need to be strengthened in all countries.

The WHO's recommendations on the treatment of MDR-TB must be referred to here for a better understanding of the evaluation of the projects below. Even though an inpatient stay is generally recommended for the complicated therapy, the WHO also advocates outpatient treatment for low and middle-income countries, like those in the Caucasus region, due to the high associated costs.

Relevance

The project addressed a very important problem in the health care systems of the partner countries involved. TB transmission, particularly among the poorer populations in the Caucasian countries, was one of the most pressing challenges in the health care sector both at the time of the project appraisal (PP) and still today. However, of particular relevance is the fight against bacteria that are resistant to the two common and most effective drugs, isoniazid and rifampicin, which are often referred to as first-line drugs[1] (MDR pathogens). Switching to what are known as second-line drugs significantly increases the cost of treatment. Longer treatment times, more dangerous side effects and last but not least the increased costs for alternative drugs with usually less successful treatment make the fight against MDR-TB even more important. MDR rates are significantly higher in almost every country of the former Soviet Union. The WHO describes it as a "public health crisis in the European region" and thus also keeps an eye on the South Caucasus. Both the Millennium Development Goals (MDGs, valid until 2015) effective at the time of the PA and the Sustainable Development Goals (SDGs, target year 2030) valid today are designed to fight TB effectively. Improving diagnostic/treatment options is eminently important for success in this area. For two decades, the countries involved in the project have consistently embedded TB control into their strategic planning for the health care system. They regularly publish 5-year plans on how to combat the disease. All three countries are listed on the WHO's High TB Burden Country List 2018 because the number of people infected per 100,000 inhabitants is over 20 and TB ranks high among the most common causes of death.

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1 The English term first-line drugs is also used in the German document.

The economic and social relevance of the fight against TB and the rates of MDR and drug-resistant XDR cases (caused by extremely or extensively resistant TB bacteria), some of which are still on the rise, is also high. For example, in Georgia, a country with a population of 3.9 million, the cost of TB control in 2016 alone was about USD 20 million[2]. This is about USD 5 per capita, which is an important figure with annual per capita income of just under USD 3,700 (Atlas method). Further, there is a very high dependency on external donors such as the GFATM (Global Fund to Fight AIDS, Tuberculosis and Malaria), but also on USAid and global civil society organisations.

The relevance of the programme implemented in 2008-2011 was not very high in terms of financing volume. FC invested an average of just over EUR 1 million per year. According to experts, however, the estimated expenditures of the three countries in the same period were 30 times higher. However, it would be a mistake to assess the relevance of the FC contribution to the fight against TB solely based on numbers. The impact chain is also plausible and relevant from today's perspective as it contributes to improving diagnosis of the infectious disease and thus to breaking the TB infection chain by financing measures such as the establishment of a new national reference laboratory (NRL) in Georgia and, for example, the newly equipped regional culture laboratories in Azerbaijan. However, it would have been preferable and possibly feasible for FC to focus even more clearly on the targeted diagnosis and treatment of MDR-TB, a rampant problem in the countries, especially in view of the limited financing volume under the project.

Relevance rating: 2 (all projects)

Effectiveness

The programme objective (outcome) of all three projects was to contribute to improving the diagnosis and treatment of the various forms of TB, including MDR-TB. Achievement of the project's objectives can be measured using the following indicators and can be summarised as follows for the ex post evaluation:

Indicator	Status PA, Target PA	Ex post evaluation****
(1) Increase in the case detection rate*	Armenia: Status PA: 60% Target PA: min. 73% Azerbaijan: Status PA: 54.6% Target PA: min. 73% Georgia: Status PA: 90.9% Target PA: min. 73% (defined for all countries across the board as the target)	The value of the indicator has not been published by the WHO since 2013. Armenia: 79% (2012). Achieved. Azerbaijan: 72% (2012). Narrowly missed. Georgia: 78% (2012). A decrease has been observed since the PA.
(2) Treatment success rate of new smear positive patients**	Armenia: Status PA: 72.5% Target PA: 85% Azerbaijan: Status PA: 60.2% Target PA: 85% Georgia: Status PA: 67.6% Target PA: 85%	Current status: 79% Current status: 83% Current status: 84% Not achieved in any country.

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2 Source: WHO Global TB Reports. The figures published in 2017 relate to the year 2016.

(3) Increase in the DST Coverage Rate	Armenia: Status PA: 12% Target PA: 90%	Current status: 96%
	Azerbaijan: Status PA: 10% Target PA: 90%	Current status: >100%***
	Georgia: Status PA: 90% Target PA: 100%	Current status: 95% Achieved except in Georgia.

* The WHO's estimated number of new cases of all forms of TB

** At the time of the PA, the indicator related solely to newly identified infectious TB cases. Today, this also includes relapsed patients who have already been previously treated. To this extent, it is no longer just a question of new cases, but also of cases already treated once in the past.

*** Inconsistent information may be the result of incorrect reconciliations between laboratory and clinical registries.

In recent years the countries involved have made the greatest progress in the diagnosis of TB (Indicator 3). This also affects, most importantly, the drug susceptibility tests (DST, "sensitivity testing of TB bacteria to the common first-line drugs"). Progress has been particularly substantial in Armenia and Azerbaijan, which at the time of the project appraisal still had very low baseline values. Georgia has also made some progress, despite the high level at the outset, even though it was not possible to reach the unrealistically high target of 100%. The example of Azerbaijan, with a value higher than 100%, also shows the limits of the indicator and the way it is calculated, which can evidently involve double counting due to inadequacies in data collection and processing and therefore cannot always be calculated reliably. However, visits and discussions carried out as part of the ex post evaluation did not leave any doubt that the use of DST tests is the rule in all participating countries and that not using these tests is the absolute exception.

Since it was already clear at the time of the project appraisal how important the fight against MDR patho-gens would be, it would likely have been advisable to shore up the project's focus on this area by prioritis-ing the measures to be financed and by using a meaningful indicator for MDR-TB. For the successful fight against MDR-TB, a DST is necessary to help decide whether the simple (first-line) therapy will be suffi-cient to treat the patient, Yet in order to make an exact diagnosis in the case of MDR or XDR-TB, other microbiologically sound, logistically complex and expensive analyses are required. The existence and quality of national reference laboratories (NRL) and regional culture laboratories are important to accu-rately diagnose MDR-TB. The availability of qualified personnel in these labs is an important prerequisite for the health care systems in question, as well as suitable logistics structures for the transport of patients' sputum and tissue samples. The three countries in the regional programme have very different situations in this respect.

Georgia: the decision to replace an outdated national reference laboratory (NRL) in Tbilisi/Georgia with a new NRL and to finance it from FC funds was consistent and correct. Unfortunately, however, ten years after the planned project start in 2008, it has still not been put into operation (as of July 2018). NRLs play a prominent role in advising all health care institutions involved in diagnosis and treatment in their respec-tive countries. An accurate MDR diagnosis is eminently important because it serves as the basis for the subsequent TB treatment, which can only be as good as the accuracy of the diagnostic options. The in-vestments in NRLs are therefore an integral part of a successful response to MDR-TB.

Azerbaijan: in the case of Azerbaijan, it was certainly right to reallocate budget lines that were actually in-tended for first-line drugs and to use them for equipping regional culture laboratories. However, based on the ex post perspective, it seems appropriate to ask why the project did not focus more clearly on MDR-TB from the outset and why, in particular, the diagnosis of TB and also the outpatient care approach, which is the method of choice according to WHO criteria, were improved (see Relevance criterion). This would have contributed more effectively to the target achievement.

Armenia: in general, none of the countries involved in the project has yet been able to reduce the capaci-ties of inpatient TB treatment in favour of outpatient TB treatment. This is particularly evident in Armenia. Inpatient TB facilities still exist here, with budgets for maintenance and personnel that require large

amounts of money every year. It is difficult, however, to enforce closures of inpatient facilities in favour of outpatient treatment – even if they are far from an acceptable level of capacity utilisation.

The three countries face major challenges in providing flexible, needs-driven, across-the-board TB patient capacities that enable patients to continue to lead a normal life. Active screening of the population for TB cases would also have to be stepped up in order to increase the effectiveness of TB control. In every case of TB it is necessary to analyse the patient's entire environment and to investigate whether other family members, friends or contacts in the patient's private or professional environment are affected by the infection. This does not happen to the necessary extent, as some of the partners openly admit. Thus, to achieve this at all, flexible units closely linked to basic health care services would be important. Further, there are challenges, for example, in convincing those affected and their immediate surroundings to undergo a diagnostic test even in a suspected case. Also, it is not easy to carry out the series screenings within a timeframe acceptable to those affected and then offer treatment to the patient in line with their needs and close to the patients residence. Clearly, improvements are needed here because any MDR/XDR case that goes undetected and thus untreated is a burden on the future and stability of the health care systems in the relevant countries.

The effectiveness is rated as satisfactory or unsatisfactory as the indicators have only been partially achieved, and due to the high risk of the MDR/XDR problem being insufficiently addressed.

Effectiveness rating: Azerbaijan 3, Armenia 3, Georgia 4

Efficiency

The Project implementation was considerably delayed for various reasons. The programme was initially scheduled to run for 24 months. This timeline was exceeded by far. The implementation took 42 months in Armenia, 75 months in Azerbaijan and 73 months in Georgia. If the delays in the NRL in Georgia described above are also taken into account, the delays are even longer. Although it was communicated to the evaluation mission that the opening of the NRL was imminent, there were still those in July 2018 who expected further delays. The reasons were partly external (armed conflicts between Russia and Georgia, bankruptcy of the originally contracted construction company, new tender required for the remaining work). Other reasons for delays could, however, have been avoided or at least limited by better construction planning and management. These include changes in plans for construction[3] and equipment for laboratory diagnostics, changes in regulations for the technical design of ventilation systems[4] and approval challenges associated with the modified plans described above. For example, the entire basement of the building, which was not originally planned or approved, was not communicated proactively to the local authorities in advance, resulting in a delay of months. The project executing agency and consultant could have possibly prevented some of these delays.

The government structures for procurement are generally inefficient and in some cases represent a considerable impediment to the effectiveness of the national TB programmes. Particularly, this is evident in the procurement and distribution of TB drugs (effects on production efficiency). The continuous availability of medication is particularly critical to successfully treating TB because even short-term interruptions in the treatment can lead to mutations in the pathogens in question and thus trigger MDR-/XDR-TB cases. At the central level, strict requirements for the procurement of TB drugs pose a major problem. In Armenia, for example, the procurement of medicines must first be tendered at national level. Therefore, only when these tenders fail it is permitted to tender TB drugs internationally or – sometimes with special permission – ordered directly from the Global Drug Facility (GDF) in Geneva. This procurement channel is generally favoured by WHO experts. The batches of medicine to be procured from small countries are too insignificant to be of interest to efficient suppliers. For example, the price offered by national suppliers is ten times that of the GDF. Although the problem is well known, it has not yet been possible to establish special rules for TB procurement that allow a pragmatic approach to solving these challenges. In the past, international donors or NGOs have often mitigated the consequences of failed tenders and the excessively long procurement processes as a result by bridging imminent stock shortages with rapid procurements from the GDF or other contract partners. Despite that, even more worrying is the fact that major donors

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3 Originally, the NRL did not include a basement, nor was it approved.
4 According to the WHO's criteria, ventilation systems must now guarantee 20 times the air change rate per hour (previously 12 times).

(GFATM, USAid) now want to withdraw shortly from the participating countries, but, at least as far as Armenia is concerned, no visible steps have been taken to ensure more efficient and robust procurement. During the evaluation mission, experts familiar with the situation in Armenia warned of a short-term risk of a considerable bottleneck in the storage of first-line drugs. The distribution of the medicine is also likely to be a key problem. In a hospital department specialising in TB in Azerbaijan, the evaluation mission happened to find a hospital pharmacy where only very small stocks of (first-line) TB drugs were on hand.

The weak utilisation of hospital capacities for inpatient treatment, which eats up a large share of the GFATM-financed tuberculosis budget for maintenance and does not meet the requirements of modern TB treatment, can also be rated as inefficient.

EUR 1.3 million (30% of FC financing) was used to finance first-line drugs. In addition, expenditure for the implementation consultant amounted to some EUR 1.1 million (24%). Part of the consultant costs were aimed at addressing the regional dimension of TB and helping the countries to develop or agree on coordinated ways of combating disease. Consulting costs are therefore higher than what is usual for comparable projects. With regard to the small-scale nature of the measures, we consider them to be only just appropriate. The consultant also provided advice on preparing GFATM applications, which made sense given the complexity of these applications. The remaining financing flowed into laboratory equipment and other infrastructure for MDR-TB treatment. The FC investments, which were also quite low for a health care project, have triggered effects, which mean allocation efficiency was good.

Efficiency rating: 3 (all projects)

Impact

The overarching developmental objective (impact) was the contribution to break the chain of TB infection. According to the available data, all countries involved in the project succeeded in drastically reducing TB-related morbidity, i.e. the number of new TB-related illnesses, and also significantly reducing TB-related mortality within eleven years (see table below).

Indicator	Status PA, Target PA	Ex post evaluation
(1) Annual number of new cases of infectious pulmonary tuberculosis (incidence rate) per 100,000 inhabitants in 2015 meets the following country-specific MDG targets	Armenia: Status PA: 31.9 (2005) Target PA: 14.6 Azerbaijan: Status PA: 34.0 (2005) Target PA: 15.6 Georgia: Status PA: 37.1 (2005) PA target value: 17	Status 2017: 12 Status 2017: 22 Status 2017: 19
(2) Decrease in TB mortality per 100,000 inhabitants. No target value defined.	Armenia: Status PA: 10 Azerbaijan: Status PA: 10 Georgia: Status PA: 9	Current status*: 2.1 Current status*: 6.4 Current status*: 4.8

* Source: WHO Global TB Reports. The figures published in 2017 relate to the year 2016.

According to statistics available from the WHO, Armenia currently has the best situation. In 2017 there were 12 new TB-related cases per 100,000 inhabitants. On average, 2.1 people per 100,000 die of TB every year. Armenia was thus able to achieve a decrease of 79% (mortality) in the indicators between 2005 and 2016.

The data made available to the WHO has not been very reliable over the years. An analysis of the figures reported by the countries to the WHO as part of the ex post evaluation showed extreme fluctuations in both incidence and mortality between the individual years (up to 16 times the WHO figures[5]). It can also be observed that the data made available to the WHO is sometimes changed several times in later annual reports after it has been made available, and that the data differs by up to twice as much. This suggests that there are systematic challenges in data collection. It is conceivable, of course, that the relatively small basic populations in the countries participating in the project are sometimes decisive and that the erratic changes are the result of random fluctuations. The fact that the largest change occurred in Azerbaijan and that mortality rates vary so markedly may indicate that the data quality is not reliable.

In all participating countries, experts criticise the fact that the diagnosis and treatment of tuberculosis has a highly vertical structure, i.e. that there are specialist TB units that work exclusively on this disease. The integration of TB-oriented services into the population's general basic health care has been inadequate, if at all. It can therefore be assumed that a high percentage of incidence and TB-related mortality is not always correctly detected and thus documented. It is also not very helpful that the available data on morbidity and mortality do not correctly reflect the development of multi-resistant TB pathogens.

A positive trend emerges overall despite the lack of reliable data, which is why the project's contribution to the overall objective is rated as good.

Impact rating: 2 (all projects)

Sustainability

The countries involved in the project invest a large annual amount in the fight against TB. This has been the case for many years and there was no indication during the mission that they intend to limit this amount. A major risk in terms of sustainability, however, is that the GFATM, which finances significant parts of the fight against TB in all three countries, will declare its intention to withdraw from the countries after the current financing rounds. This, as well as the planned withdrawal of USAid and MSF from the region, will inevitably lead to substantial increases in national TB budgets, and it is not yet clear whether the governments will be able to increase the budget for TB control. Even if it is assumed that these budget increases will take place, there are considerable doubts as to whether, for structural and personnel reasons, the governments will be able to guarantee a high-quality standard of TB service even without the GFATM and to keep the equipment, which is still well maintained today, current and up to date in the future. As in the past, the countries have only succeeded to a small extent in creating structures that can proactively search for existing TB-infected persons. Every undiscovered case, especially of people infected with MDR/XDR, however, poses a high risk for the respective environment. TB control is still vertically organised and inadequately integrated into the respective health and basic care systems. Very serious structural problems also persist in the way TB drugs are procured and distributed to specialised TB units. After GFATM withdraws, there could be considerable supply bottlenecks due to the frequent lack of qualified personnel at national level who are able to guarantee a continuous supply of the necessary first, second and third-line drugs despite complicated procurement rules and logistic structures. In the areas where governments are already responsible for the procurement and distribution of drugs (first-line drugs), there was a threat of a supply bottleneck during the ex post evaluation mission in one country at national level and very few drugs were available in a specialised hospital in another country. Major sustainability problems could also be due to the challenging personnel situation for TB in the participating countries. Due to the risk of infection, only comparatively few qualified doctors, nurses and laboratory technicians are prepared to fight TB. Wages are also low. In one of the countries, the KfW mission was told that nurses from inpatient TB hospitals were not retiring because of the extremely low pensions they could expect. At the same time, however, staff for outpatient care facilities is lacking.

With regard to the sustainability of TB control, one positive aspect is that all the countries participating in the regional programme use considerable budget funds to combat the disease. This is not a current development, government funds have been flowing for many years. As donors withdraw, the future focus will be on using these funds more effectively and efficiently. Although this will not happen without friction, the discussions on-site have not provided any evidence that the countries participating in the regional pro-

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5 TB mortality in Azerbaijan is reported to have increased from 0.39 to 6.4 per 100,000 inhabitants between 2016 and 2017.

gramme are unaware of their future responsibilities. The future will show to what extent countries will succeed in pursuing independent and sustainable TB control strategies.

Sustainability is thus assessed as satisfactory for Georgia and Azerbaijan, but no longer satisfactory for Armenia. The country still relies too heavily on inpatient structures in the fight against TB. Significant TB funds are used to renovate inpatient TB facilities that are hardly or no longer needed. In addition to buildings, this also affects the staff costs of employees working in inpatient TB facilities. However, funds are lacking in areas where the outpatient approach to treating TB needs to be promoted. The private sector plays no role at all in the fight against TB. This means that the government is the sole actor, both throughout the country as well as in terms of all activities related to TB control. However, the government is overstrained by the number of functions (central procurement of medicines, patient-oriented TB care, provision of doctors who can carry out TB-relevant operations).

Moreover, although TB control is a problem that does not stop at the borders of the respective countries, too little dialogue takes place with the partner countries on the challenge of migration. In some cases, people infected with TB receive whole monthly rations of medication for a business trip to Russia or other neighbouring countries, which they are then supposed to use without supervision in the destination country.

Sustainability rating: Azerbaijan 3, Armenia 4, Georgia 3

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

Projects 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).