Ex post evaluation – Kazakhstan

Sector: Infectious disease control (CRS code 12250)
Project: National Tuberculosis Control Programme I and II in Kazakhstan (BMZ no. 1999 6650 8 and 2000 6582 1*)
Implementing agency: Ministry of Health of Kazakhstan

Ex post evaluation report: 2020

	Phase I (Planned)	Phase I (Actual)	Phase II (Planned)	Phase II (Actual)
Investment costs (total) in EUR million	3.78	3.78	4.26	4.44
Counterpart contribution in EUR million	1.22	1.22	1.70	1.90
Funding in EUR million	2.56	2.56	2.56	2.54
of which BMZ budget funds in EUR million	2.56	2.56	2.56	2.54

*) Random sample 2019

Brief description: Both phases of the FC project supported Kazakhstan's National Tuberculosis Control Programme, which is being implemented in line with WHO recommendations. To this end, a contribution was made to improving the diagnosis and treatment of the various forms of tuberculosis (TB) according to the DOTS strategy (Directly Observed Treatment, Short Course) recommended by the WHO. The project was part of a regional network comprising similar German FC projects with Kyrgyzstan, Tajikistan and Uzbekistan.

Core measures in the two phases included equipping civil healthcare facilities and, to a lesser extent, prisons with modern laboratory and medical equipment as well as consumables. Equipment was also provided to the National Tuberculosis Centre of Kazakhstan (now the National Scientific Centre of Physiopulmonology, NCPT) and the National Reference Laboratory for Tuberculosis.

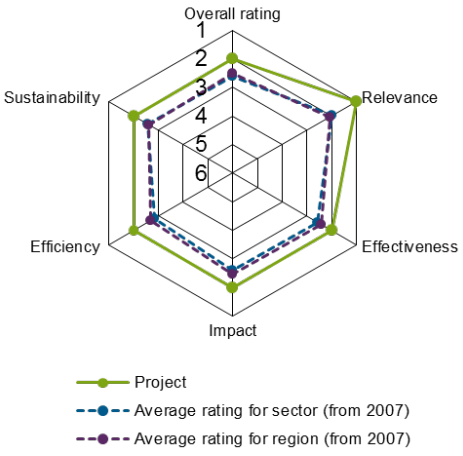
Objectives: The project objective (both phases) was to improve the diagnosis and treatment of the various forms of tuberculosis in the programme regions, thereby helping to combat the spread of tuberculosis in the programme regions (outcome). This was designed to help interrupt the chain of infection and thus contain the TB epidemic in the programme regions (impact).

Target group: The target group comprised the population living in the five programme regions: North Kazakhstan, Aqmola, Kyzylorda Oblasts (Phase I), South Kazakhstan and Aqtobe (Phase II). Since the danger of contracting tuberculosis depends to a large extent on the respective social living conditions, it was assumed at the project appraisal that the poor would benefit most from the projects.

Overall rating: 2 (Phases I and II)

Rationale: In recent years, the Kazakh government has made considerable progress in the fight against tuberculosis (e.g. improving outpatient treatment and primary health care, improving the data management system) and in particular the diagnosis of tuberculosis. The project contributed to these developments by improving diagnosis and treatment. Moreover, adjustments in the focus of the national TB programme and the optimisation of the TB laboratory network have increased efficiency and had a positive impact on the sustainability of the project.

Highlights: The TB programme is largely financed from the national budget. The diagnosis and treatment of tuberculosis is also free of charge for immigrants from other countries. TB patients receive monthly financial support, which contributes to the success of treatment.



Rating according to DAC criteria

Overall rating: 2

Ratings:

Relevance	1
Effectiveness	2
Efficiency	2
Impact	2
Sustainability	2

Note:

Phases I and II of the programme to combat tuberculosis in Kazakhstan had identical concepts and were assessed together during the evaluation. The evaluation therefore covers both phases of the project.

The report compares the project with a similar project in Kyrgyzstan Phase III and IV (BMZ no. 2005 66 224 and 2006 66 339), which was part of the same regional network.

Relevance

After the fall of the former Soviet Union (1991), tuberculosis (TB) became widespread in Kazakhstan, similar to the other Central Asian republics and the Caucasus region. The morbidity rate rose from 60 to 165 cases per 100,000 inhabitants between 1993 and 2002. The mortality rate underwent a similarly dramatic development from around 17 (1994) to 38/100,000 (1999). The situation was particularly serious in prisons, where around 10-15% of the 80,000 prisoners suffered from active TB. One of the reasons for the high prevalence of TB was the inefficient structure of health care, which, as in the other countries of the former USSR, was too extensive, fragmented and overspecialised, with a focus on curative treatment. The strained economic and social situation in Kazakhstan in the 1990s also contributed to the accelerated spread of the disease.

From around the mid-1990s, the Kazakh government placed the fight against TB at the centre of its health care policy, which was reflected in the government's 1998 health sector reform programme. In this context, the WHO-recommended DOTS strategy[1] was introduced in 1998. Despite initial resistance, the first successes of the improved diagnostic and therapeutic approach of the DOTS strategy became evident during the project appraisal at the end of the 1990s and beginning of the 2000s. At the same time, since the end of the 1990s Kazakhstan has increasingly had to contend with the rising rate of drug resistances, which develops when the patient stops taking medication prematurely. In this context, the often unregulated migration of people in search of work within Kazakhstan and in the entire region plays an important role

In order to create the conditions in TB laboratories for new laboratory test methods according to the DOTS strategy, Kazakhstan needed additional financial resources. In terms of diagnostics, the projects evaluated here (Phases I and II) were closely linked with the DOTS strategy. The impact logic of improving the diagnosis and follow-up treatment of the various forms of TB in the programme region by strengthening the implementation of the DOTS strategy and thus breaking the chain of TB infection in the programme region through the provision of functional equipment in the health care facilities, laboratory equipment in particular, is also plausible from today's perspective. At the time of the project appraisal, there were still considerable deficits in TB diagnostics, general hospital equipment and data management. The TB laboratories did not meet the required biosafety criteria to prevent contamination in the laboratories and to guarantee the reliability of the tests. In this context, the project approach is highly relevant as the selected

[1] DOTS strategy (Directly Observed Treatment, Short Course) means that patients take their medication under the supervision of medical staff until they recover.

laboratories were provided with new equipment to replace outdated laboratory equipment. With regard to laboratory equipment, there was a clear division of responsibilities with the Global Fund to fight AIDS, Tuberculosis and Malaria. Further contributions (TB drugs, new diagnostic technologies, training, better reporting systems, etc.) were provided by the national TB control programme through the national budget and other donors (including WHO, USAID, KNCV Tuberculosis Foundation). In this respect, the work complemented the approaches of other donor institutions.

The project region was selected in consultation with the Ministry of Health and the donors supporting the TB programme. At the time of the project appraisal, each region generally needed support for TB control. Ultimately, the deciding factor in whether the region was selected was that no other donors were active in the project region, thus ensuring that the investments of other donors were complementary.

The strategic decision to involve the National Reference Laboratory (NRL) in the project was highly relevant, as it is responsible for the quality assurance of the diagnostic work in the laboratories at Oblast (regional) level. This has made a significant contribution to improving the diagnosis of various forms of TB. Compared with the TB programme in Kyrgyzstan (Phases III and IV), where investments were made in new infrastructure and equipment for an NRL, the TB programme in Kazakhstan pursued a different approach. In addition to equipment for the NRL, the laboratory network in particular was strengthened. This approach seems more appropriate for Kazakhstan given the size of the country.

Despite the good progress made, TB remains a serious problem. According to the WHO, Kazakhstan is among the 30 countries most affected by the various forms of drug resistance (MDR/RR-TB, XDR-TB)[2]. The relevance of the project is thus rated as positive, not only in hindsight but also from today's perspective. Although MDR-TB diagnosis has improved considerably since the time of the project appraisal due to groundbreaking innovations (introduction of molecular biological tests such as Hain Lifescience, Xpert MTB/Rif), which make it possible to diagnose TB earlier and more accurately, the importance of the equipment funded by the project remains high. This relates not only to the improved working conditions in the laboratory, but also to the diagnostic cultures funded under the project. This is still indispensable for the differential diagnosis of resistance to specific drugs and for monitoring the treatment of TB patients, as the range of resistance detectable with molecular biological methods remains limited.

In Kazakhstan, non-communicable diseases, which are estimated to account for 86% of deaths due to illness, are becoming increasingly significant. Cardiovascular diseases are at the top of the list, followed by cancer and respiratory diseases.[3] Still, investment in the diagnosis and treatment of TB remains highly relevant, particularly due to widespread drug resistance.

In summary, it can be said that the project approach was consistent with WHO standards and that the project objective had the potential to contribute to achieving Millennium Development Goal 6 (MDG 6, combating HIV/AIDS, malaria and other diseases). Today, the fight against tuberculosis remains a high global priority as expressed in sub-section 3.3 of the Sustainable Development Goals.

The Kazakh government continues to give high priority to TB control in its health strategy, as evidenced by the large budget for combating TB and the TB control strategy (Complex Plan for Tuberculosis Control in Kazakhstan 2014 - 2020).

Relevance rating: 1

Effectiveness

The programme objective (outcome) of both phases was to improve the diagnosis and treatment of the various forms of TB in the programme regions. At the time of the EPE, the following indicators can be used to measure the success of the objectives at outcome level:

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[2] MDR = multidrug resistance; RR = Rifampicin-resistant; XDR = extensively resistant TB with additional resistance to defined second-line drugs.

[3] https://www.who.int/nmh/countries/kaz_en.pdf?ua=1

Indicator	Status PA, target PA	Ex post evaluation[a]
(1) Improve the DOTS detection rate for TB, defined as the ratio of new smear-positive cases to the total number of expected cases	Status PA: n.a. Target value: 70%	2018: 100% (fluctuation range: 72-160)
(2 a) Improve the DOTS treatment success rate defined as the ratio of successful treatments through recommended short-term therapy for new smear-positive cases	Status PA: n.a. Target value: 85%	National (2018): 91%
(2 b) Improve the treatment success rate for MDR/RR-TB cases (2 c) Improve the treatment success rate for XDR-TB cases	Status PA: n.a. Target value: n.a. b) Treatment success rate for MDR/RR-TB cases ("cases started on second-line treatment in 2013"): 72% c) Treatment success rate for XDR-TB cases ("cases started on second-line treatment in 2013"): 30%	b) Treatment success rate for MDR/RR-TB cases ("cases started on second line-treatment in 2016"): 80% c) Treatment success rate for XDR-TB cases ("cases started on second-line treatment in 2016"): 48%
(3) Decrease of notified new and relapse cases of TB	Status PA: n.a. Target value: n.a. 2010: 28,550 cases	2018: 12,832 cases (decrease of around 55%)
(4) Percentage of all new smear-positive TB cases submitted to DST (Drug Susceptibility Testing)	Status PA: n.a. Target value: n.a.	2017: >100%[b)]

[a)] Data for indicators 1 - 3 according to WHO, Tuberculosis Profile Kazakhstan 2018

[b)] WHO (2018): Global Tuberculosis Report, p. 77 (the figure relates to Rifampicin). According to the report, the percentage can exceed 100% if "e.g. samples rather than cases are counted in the numerator; laboratory specimen results are not linked to the denominator data source when enumerated; or there is incomplete reporting of bacteriologically confirmed cases in the denominator".

Indicator 1: The case-detection rate has risen continuously and is with 100% (fluctuation range 72 - 160) above the target value. However, the figure is associated with considerable uncertainty. Discrepancies between the estimated number of new cases and actual figures reported are due to a combination of underreporting of detected cases and underdiagnosis (lack of access to health care or undiagnosed TB).[4] In addition, due to the complex impact chain and substantial changes in TB diagnosis through the introduction of genetic engineering methods, the FC measure can only be partially credited with improving the indicator.

[4] WHO (2018): Global Tuberculosis Report.

Indicator 2: The target value for the treatment success rate was exceeded (2a). The treatment success rate for resistant forms of tuberculosis (2b and c) also improved. The treatment success rate for MDR/RR-TB in Kazakhstan is far above the average of 55% compared to countries with a high MDR/RR-TB rate according to the WHO Global TB Report of 2018.[5]

Indicator 3: The number of newly reported and relapsed TB cases has decreased by 55% between 2010 and 2018.

Indicator 4: According to the WHO Global TB Report 2018, 100% of all smear-positive cases in Kazakhstan undergo drug resistance testing. This figure is the same for Uzbekistan, while the figure for Kyrgyzstan is 80% and for Tajikistan 89%.

In summary, it can be said that the FC measures have contributed to improving the diagnosis of tuberculosis. The NRL, which was equipped under the project, has also contributed to correct and efficient treatment by means of quality control of the diagnostics in the lower-level TB laboratories. This is particularly important for containing MDR-TB and RR-TB and makes an important contribution to preventing far more serious consequences. It has been proven that the treatment of MDR-TB cases with first-line drugs or an incorrect selection of second-line drugs promotes the development of extremely drug-resistant TB (so-called XDR-TB).

Effectiveness rating: 2

Efficiency

The project implementation was extremely delayed. While three years were planned for the implementation of each phase, the actual programme term was extended to 12 years for Phase I and to about 8 years for Phase II. The considerable delays were mainly due to prolonged contract negotiations, several repetitions of the international tendering processes for laboratory equipment and medical devices and complicated import regulations (import duties). Due to the delays in implementation, the costs increased, particularly for consulting services. They also affected the work of the NRL. The building was refurbished with GF funds and could only be newly equipped with FC funds some time later. According to the director of the NSCP, however, the multiple tendering processes and challenges in importing the goods also had a positive learning effect on the national TB programme. The tendering processes are now carried out very efficiently without major difficulties.

The total costs (FC share) of the programme, at EUR 5.1 million (Phase I and Phase II), were slightly lower than estimated at the project appraisal and are considered appropriate, particularly in consideration of the international tendering process. The samples takenduring the evaluation showed that the FC-financed laboratory equipment is used as intended as part of the national diagnostic algorithm and that the laboratory capacities newly created under the programme are largely well utilised. In addition to new/modern molecular biological tests (e.g. GeneXpert and Hain diagnostic tests), FC-financed diagnostic cultures are still routinely carried out for all newly diagnosed cases. This could be seen as inefficient when compared to international standards. However, in view of the high number of MDR/RR-TB and XDR-TB cases in Kazakhstan, this methodology is still considered suitable, as diagnostic cultures can detect a broader range of drug resistance.

As a result of the reorganisation and optimisation of the TB network in Kazakhstan, some of the FC-financed laboratory equipment was redistributed. At regional level, this made it possible to equip more laboratories with devices than originally planned. This can be deemed very positive from the perspective of allocation efficiency. The reorganisation also affects the prisons. While it was still assumed at the appraisal that the prisons largely diagnose TB themselves and therefore had equipment, the recording and diagnosis of TB diseases is now mainly carried out by the specialised TB laboratories in the public health system. This is also intended to ensure that prisoners who are ill are treated without any transition period after their release.

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[5] "Treatment success (of drug resistant TB) remains low, at 55% globally. Examples of high burden countries in which better treatment success rates are being achieved include Bangladesh, Ethiopia, Kazakhstan, Myanmar and Viet Nam (all of which have rates above 70%". p. 3

The accompanying measures to increase the capacity of the laboratory staff are important for the assessment of efficiency. They are cost-effective to the extent that the impact of the training, which is mainly provided by other donors and national funds, will continue to have a positive impact on maintenance, staff retention and sustainability. The positive effect of training was evident when visiting the project locations: the laboratories, equipment and other facilities visited were in good condition. There were sufficient consumables available in the facilities visited. The storage of consumables was found to be adequate in all TB laboratories visited. The laboratory employees are motivated, committed and familiar with their responsibilities. This also applies to the laboratory managers. Training is planned for laboratory staff in the future as well.

Despite the low salaries for laboratory staff (mostly women), staff turnover seems to be quite low. However, it should be borne in mind that much of the staff will reach retirement age in the coming years, so new staff will have to be recruited well in advance.

Improving the laboratory equipment has increased the laboratory capacity and the laboratories are working more efficiently. According to the laboratory staff interviewed, they needed less time to perform the individual tests, which allowed them to double the number of tests performed. The working conditions in the laboratories have also improved. According to information from the NSCP, there have been no infections among laboratory staff in recent years.

Based on information from the NSCP, very different costs are calculated regionally for treating TB patients and transferred to the appropriate TB facilities. They range from around EUR 321 to 624.[6] Efforts are currently underway to standardise treatment costs so that the same amount is paid for the treatment of a TB patient regardless of the region. TB diagnosis and treatment is free of charge for the patients. This also applies to immigrants from other countries. Still, many patients incur costs for food or transport to health care facilities. However, no data is available on this. One positive aspect is that there is social support in Kazakhstan for TB outpatients. The patients are paid about EUR 50 per month directly (this varies slightly depending on the region). This has been shown to improve the success of treatment.

Due to the increasing number of patients with drug resistance, treatment costs have increased overall in the last 20 years. These additional costs are largely covered by rationalisation efforts. The number of beds for the treatment of TB patients was drastically reduced (2008: 14,685 beds, 2018: 6,574 beds). At the same time, the number of new TB patients receiving outpatient treatment has increased, reaching almost 50% in 2018. To this end, the capacities at the level of primary health care (PHC) were strengthened. Via “telemedicine” or video-based monitoring of the intake of TB drugs, via Skype for example, the majority of outpatients are already being monitored to ensure that they are taking their medication. This saves patients time and money as they do not have to come to the health care facility every day to take their medication. As already mentioned, the laboratory network was also optimised. It consists of the NRL, which communicates directly with the 19 TB laboratories at Oblast level (regions) (of which 1 TB laboratory is located in a prison). There are about 260 laboratories at the level of primary health care. There is a clear division of responsibilities between the 3 levels.

The FC project was integrated into the national TB programme. The reform processes described in the TB programme and the optimisation of the TB laboratory network have contributed to achieving the objectives at outcome level with an appropriate use of funds.

Efficiency rating: 2

Impact

The overarching developmental objective (impact) was to help break the chain of infection, thereby containing the TB epidemic in the programme regions.

The following indicators are used by the EPE to assess developmental impacts:

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[6] The median cost per patient treated in 2017 was US$ 1224 for drug-susceptible TB and US$ 7141 for MDR-TB (WHO Global Tuberculosis Report 2018, p. 113). The expenses per patient with MDR-TB in Kazakhstan are within this range, see Annex 6, Figure “Average expenditure per patient treated for MDR-TB”.

Indicator	Status PA, target PA	Ex post evaluation
(1) Decline in the TB incidence rate (per 100,000 inhabitants) (national and programme region)	Status 1999, Phase I Nationwide: 140.8 Akmola: 149.8 North Kazakhstan: 126.4 Kyzylorda: 290.8 Status 2002, Phase II Nationwide: 165.1 Aktobe: 259.4 South Kazakhstan: 119.6	2018 (NSCP)[a)] Nationwide: 48.2 Akmola: 56.7 North Kazakhstan: 63.4 Kyzylorda: 53.5 Aktobe: 51.7 South Kazakhstan: 37.8 2018 (WHO)[b)]: 68 (fluctuation range: 44 - 97)
(2) Decline in TB-MDR/RR incidence rate (per 100,000 inhabitants)	Status PA: n.a. Target value: n.a. 2016 (WHO): 49.9	2018 (WHO)[b)]: 26 (fluctuation range: 16 - 38)
(3) Decline in TB mortality rate (per 100,000 inhabitants), (all forms, without HIV)	Status 1999, Phase I Nationwide: 38.4 Akmola: 24.6 North Kazakhstan: 26.9 Kyzylorda: 35.9 Status 2002, Phase II Nationwide: 24.2 Aktobe: 33.3 South Kazakhstan: 15.1	2018 (WHO)[b)]: 2.3 (fluctuation range: 1.9 - 2.8) (no data available for the regions)

[a)] Data was provided by the NSCP

[b)] WHO, Tuberculosis Profile Kazakhstan 2018

Both the incidence rate[7] and the mortality rate have decreased dramatically in recent years. Even though it is not possible to show a direct correlation with the FC project, the project has contributed to improving TB diagnostics in the laboratories and identifying drug resistance. This information is important for taking the right political decisions to combat TB (lobbying). On the other hand, the diagnostic results are important for the correct, individualised treatment of patients with MDR/RR and XDR-TB. Therefore, improved diagnosis of TB helps to break the chain of infection.

The project contributed to cutting microeconomic and macroeconomic costs by improving TB control.[8] TB mainly affects men of working age, who are usually the main breadwinners in their families. The people affected are restricted in their capacity and availability on the labour market over a longer period of time and suffer losses of income. Treatment is paid for by the government, but in-patient treatment and drugs for resistant forms of TB are very expensive (see Annex 6). Investments in effective diagnosis and treatment are sensible measures to contain the TB epidemic and thus limit productivity losses, both at the level of those affected and of society.

Impact rating: 2

[7] The incidence delivers high values, especially in the phase when diagnostics are initially intensified, and is also overly based on estimates, which is why there is also a high fluctuation range ("uncertainty intervals").

[8] "The socioeconomic impact of multidrug resistant tuberculosis on patients: results from Ethiopia, Indonesia and Kazakhstan (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5011357/). According to the study, patients in Kazakhstan incur costs of USD 929 for the diagnosis and treatment of simple TB and USD 3,125 for MDR-TB.

Sustainability

The fight against tuberculosis continues to be a priority for the Kazakh government. For several years, the tuberculosis programme has been largely financed from the national budget (in 2019: 94%). To this end, political decisions to increase efficiency were reached and implemented, such as the increase in the number of outpatients, reduction of beds for TB treatment, introduction of new diagnostic procedures for TB, restructuring of the laboratory network, strengthening of primary health care (PHC), online meetings and agreements between the NRL and the regional laboratories. The electronic data collection in TB laboratories, now installed at all levels, supplies qualitative data to the national TB programme for policy decisions and enables TB patients to be registered and cared for even if they move within the country.

In the laboratories and health care facilities visited, the interviewees confirmed that the supply of consumables to the TB laboratories and the maintenance of laboratory equipment is covered by the national budget. Medication procurement is also mainly financed by the national budget. Supply bottlenecks are currently not an issue.

The laboratory staff is very well trained. Advanced training is provided on an ongoing basis. This is conducted by the NRL, external experts and the laboratory staff themselves. Knowledge management works well in the laboratories, and care is taken to ensure that staff can stand in for each other on special diagnostic equipment. The division of responsibilities ensures that the laboratories function properly. The laboratories at regional level are subject to continuous quality control. The NRL is certified annually by the Supranational Reference Laboratory in Gautingen.

In terms of technical sustainability, the equipment is expected to be in operation for many years. All facilities have maintenance capacities for plumbing or electricity work, for example. Some facilities also have access to biomedical engineers. A local company, which supplied and installed all the laboratory equipment in Phase II of the project, supports the laboratories when problems occur and repairs are needed, in some cases still within the scope of the guarantee under the supply contract (TB programme Phase II). In the on-site meetings, it was confirmed that maintenance would subsequently be financed from the national budget.

In recent years, the National TB Centre has been restructured to form the National Scientific Centre of Physiopulmonology. The aim is to make more efficient use of the laboratories and facilities and continue to provide an adequate budget for the diagnosis and treatment of TB patients. Another reason for the new name and structure is the still widespread stigmatisation both in society towards TB patients and by health care personnel at all levels towards personnel working in the area of TB. The new name and expansion of the scope of responsibilities are intended to make work in the pulmonary centre more attractive and to counteract stigmatisation.

The strategic focus of the TB programme is also a guarantee of success for sustainability. The important challenges and strengths in the diagnosis and treatment of tuberculosis, infection control, data management system, financing of the TB programme, increasing efficiency and the strategic further development of the TB programme are outlined extensively and convincingly in the “complex plan for tuberculosis control in Kazakhstan 2014 - 2020”. The NSCP is currently working on evaluating the implementation of the plan and the strategic orientation for the coming years.

Compared with the time of the project appraisal, the conditions for the sustainability of the TB programme have improved.

Sustainability rating: 2

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).