KfW Development Bank

Ex post evaluation
Rural family planning, Phase I–III, Pakistan

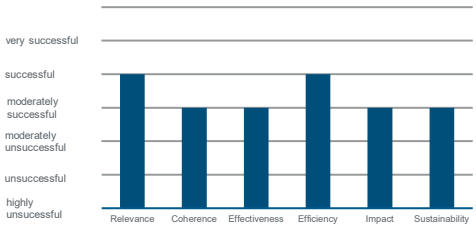
Title	Rural family planning, Phase I–III		
Sector and CRS code	13030 – Family planning		
Project number	2009 66 150, 2010 67 099, 2013 67 408		
Commissioned by	Federal Ministry for Economic Cooperation and Development (BMZ)		
Recipient/Project-executing	Greenstar Social Marketing Pakistan (GS)		
Project volume/ financing instrument	Phase I: EUR 8.0 million; Phase II: EUR 4.0 million; Phase III: EUR 2.5 million FC grant		
Project duration	2011-2019		
Year of report	2021	**Year of random sample**	2020

Objectives and project outline

The target at outcome level was to improve supply and increase use of products and services for reproductive health, provided by private health facilities, particularly in rural areas. The intention here was to contribute to improving sexual and reproductive health and rights. Target group was the poorer population in Khyber Pakhtunkhwa (KP), Gilgit-Baltistan (GB), Asad Jammu and Kashmir (AJK) and in northern Punjab (NP), as well as in a camp for Afghan refugees in Islamabad (impact).

Within the scope of the FC project, a local NGO's network of clinics in the project area was expanded and the quality was improved (social franchising approach). Equipment was also provided for a basic health services clinic operated by the local NGO in the refugee camp in Islamabad. In addition, a social marketing component was implemented, to sell subsidised contraceptives in the entire project area, accompanied by large-scale awareness campaigns. Phase I concentrated on KP; the focus of phases II and III expanded to the other provinces and regions.

Overall rating:
moderately successful



Key findings

It is plausible that the FC project contributed to expanding the range and increasing the demand and use of reproductive health services in underserved areas (outcome). It is also plausible that it contributed (even if only to a limited extent) to improving sexual and reproductive health and rights (impact).

- The project addressed urgent needs using an established executing agency with a proven approach, but it would have been preferable to forge closer coordination with the public sector to implement a total market approach. (Relevance, coherence)
- The clinics were used well and the target for contraceptive sales was exceeded; however, this did not increase the Contraceptive Prevalence Rate in the project areas. (Effectiveness)
- Production efficiency was increased significantly over the course of the project due to increased demand for contraceptives
- Sustainability remains a key challenge, due in part to the low ability to pay of the target group.

Conclusions

- The fact that franchisees are locally anchored creates trust.
- A wide range of contraceptives can help expand the use of services, despite local scepticism with regard to individual contraceptive methods, and improve the supply-side requirements for self-determination in family planning.
- Culturally appropriate awareness-raising measures focus on the health and economic benefits of longer gaps between births.
- Sustainable financing options should be considered at an early stage if members of the target group have limited funds.

Rating according to DAC criteria

Overall rating: 3

The three phases are rated together as no distinction can be made in terms of the OECD DAC criteria.

Ratings:

Relevance	2
Effectiveness	3
Coherence	3
Efficiency	2
Impact	3
Sustainability	3

Breakdown of total costs

		Phase I (Planned)	Phase I (Actual)	Phase II (Planned)	Phase II (Actual)	Phase III (Planned)	Phase III (Actual)
Investment costs	EUR million	3.43	3.43	1.58	1.58	0.13	0.13
Counterpart contribution*	EUR million	0.00	0.00	0.00	0.00	1.59	4.12
Funding	EUR million	8.00	8.00	4.00	4.00	2.50	2.50
of which BMZ budget funds	EUR million	8.00	8.00	4.00	4.00	2.50	2.50

*It was not possible to track the exact allocation of the counterpart contribution generated by the continual sales of contraceptives across the three project phases. So they are fully attributed to phase III.

Relevance

The project aimed to address key demographic and health challenges in Pakistan. Both population growth (2.2%, 2009; 2.0%, 2019) and the fertility rate (4.0 children/woman, 2009; 3.4 children/woman, 2019) were at high levels when the FC project began and at the time of the ex post evaluation (EPE), despite positive developments. They are viewed as key risks for the country's sustainable development as economic development cannot keep pace with population growth.

Key reasons for the population trend are socio-cultural factors such as social discrimination against women in economic and educational areas on the one hand, but also attitudes that include rejecting family planning for religious reasons, as well as cultural and economic motives that encourage having many children. On the other hand, a lack of access to contraceptives also plays a significant role. This is reflected in the continually low Contraceptive Prevalence Rate (35%, 2012; 34%, 2017) and a large unsatisfied demand for contraceptives (17%, 2018).

Reproductive health care is also inadequate due to the chronically under-financed public health sector, which is reflected in the particularly high infant mortality rate compared with the rest of the region (74/1,000 live births, 2012; 62/1,000 live births, 2017). Rural areas in particular are greatly affected by the structural deficits.

These outlined problems are particularly profound to some extent in the four northern Pakistani provinces that the FC project addressed. For example, the Contraceptive Prevalence Rate in Khyber Pakhtunkhwa (KP) is very low (23.2%, 2017), while Gilgit-Baltistan (GB) has one of the highest fertility rates in Pakistan (4.7 children/woman, 2017). In the camp for Afghan refugees in Islamabad that phase II began to address, there was no basic or reproductive health care. The core problem was correctly identified and the selection of intervention areas continues to seem reasonable from an ex post perspective.

The immediate target group of the project was women from the poorer population groups in KP, GB, northern Punjab as well as AJK. This target group usually has limited financial resources and can often not afford transport to public health facilities that are far away, particularly when they live in remote areas. According to information from the clinic operators and other interviewees, there is generally a high degree of poverty in the catchment areas. In addition, the target group for one component was Afghan refugees in a camp in Islamabad. The immediate target group was the clinic operators.

The results chain is plausible. Within the scope of the FC project, the intention was to support the expansion of clinics operated under a social franchising concept by the local NGO (small health stations for reproductive health) in rural, previously underserved regions in northern Pakistan (through measures including the procurement of medical commodities, equipment and medications as well as training for clinics, the financing of wages and, to a small extent, also operating costs of the local NGO). A further component included the procurement and subsidised sales of contraceptives through these clinics, and also through local private-sector entities (e.g. pharmacies), accompanied by awareness-raising and marketing activities to increase demand (social marketing component). The FC project was thus designed to contribute to improving access to and use of health services in the area of family planning and reproductive health in the project area and thus contribute to improvements in reproductive health of the population. The use of mobile clinics was planned for regions that are particularly difficult to reach. Selected pilot clinics aimed to support further training to expand the range of health services.

The additional component in a camp for Afghan refugees in Islamabad aimed to improve the refugees' access to and use of basic and reproductive health services to improve their health situation. To do this, support was provided to build a clinic which was also operated by the local NGO (support included procuring equipment and medications as well as strengthening staff capacities and supporting operation).

In view of the strain on and poor quality of state health care, the selected approach using the local NGO was understandable. Choosing the local NGO ensured that an established executing agency with an excellent reputation, strong structures and a proven concept was put in place to reach remote regions as well.

The complicated cultural context with potential reservations against services in the area of family planning was explicitly addressed in the programme approach. The services provided by the franchise clinics managed by Lady Health Visitors[1] were therefore primarily offered by women who originate fromthe respective village communities. Accompanying awareness-raising campaigns focused on issues that included the health and economic benefits of longer gaps between births. In the refugee camp in Islamabad, the intent was to increase acceptance of the measures by actively involving a committee of elders in decisions like the clinic's pricing structure. Offering a broad range of contraceptives was designed to address the potential risk of local scepticism with regard to individual methods of contraception. Women were given the opportunity to take advantage of contraceptive injections and intrauterine devices, also without the knowledge of their husbands if necessary.

The project is consistent with the Pakistani government's health targets and with the sector strategy adopted by German development cooperation in 2013 in the Pakistani health sector.

The relevance is rated in line with expectations.

Relevance rating: 2

Coherence

The FC project evaluated here is connected to a previous project "Reproductive Health / NWFP" (BMZ-No. 2005 65 010) and expanded its focus to rural regions and beyond the KP province. It was part of the DC programme "Support for health system development in Pakistan", which aimed to facilitate access to high-quality and affordable health services, particularly for poor and vulnerable groups, and was implemented in the DC programme's focus region. The FC project evaluated here was the only one within the programme with an explicit focus on family planning and reproductive health.

[1] Lady Health Visitors are trained health professionals who offer basic health services and services in the area of maternal and child health in urban and rural communities.

Even though the local NGO generally maintains good relationships with the regional Department of Health, the project did not include the public sector in its implementation. This was due, to a lack of capacity at the Ministry of Population Welfare – which was responsible at the national level – and the subsequent levels. However, the lack of state involvement implies the risk of receiving insufficient political support for the project, and makes it more difficult to coordinate and provide market coverage to the fullest extent possible in line with a total market approach (also see Efficiency).

Active coordination with other donors in the Pakistani health sector did not take place within the scope of the FC project. Other donors such as USAID and the British Foreign Commonwealth and Development Office (FCDO) also supported the local NGO's activities in this context. This ensured there was no overlap in the financing of individual health facilities from different donor funds during the term of the FC project. At the same time, the NGO ensured that the promoted clinics would receive sufficient funds from other donors after the conclusion of the FC project so they could continue operating.

Due to shortcomings with regard to the inclusion of the public sector and limited coordination with other donors, the coherence of the project is rated as moderately successful overall.

Coherence rating: 3

Effectiveness

The target of the project at outcome level was to improve supply and increase use of products and services for reproductive health, provided by private health facilities, particularly in rural areas. The target achievement can be summarised as follows.

Indicator	Target value PA		Status PA**		Status EPE	
1. Contraceptive Prevalence Rate (modern methods) Status PA: PDHS 12/13 Status EPE: PDHS 17/18	Region		Total:	Rural	Total:	Rural
	KP	20.7%	19.5%	17.3%	23.2%	22.1%
	GB	20.7%	28.2%	-	30.2%	-
	Punjab	25%	29.0%	27.4%	27.2%	25.4%
	AJK	25%	-	-	19.1%	18.2%
2. Couple Years of Protection (CYP) due to contraceptives sold by the local NGO	2 million CYP		0.4 million CYP/year		3.6 million CYP overall (Final inspection 2018)	

	Trend for the year (through clinics promoted by the project)							
	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020
3. CYP for all clinic types	26,812	42,270	46,256	57,074	76,472	53,119	24,362	26,618
3.1 CYP for rural clinics	-	-	6,396	27,839	24,933	30,614	15,426	19,787

3.2 CYP for pilot clinics	-	-	-	1,802	3,858	3,610	8,866	6,782
3.3 CYP for mobile health services	26,812	42,270	39,829	27,401	47,652	18,715	-	-
3.4 CYP for the clinic for Afghan refugees		42,270	31	32	29	180	70	49
4. Number of people visiting the clinic for Afghan refugees (women and children)	-	-	2,478	4,268	7,095	12,720	13,223	8,743

**Figures from the Pakistan Demographic and Health Survey (PDHS) 06/07 were used during the project appraisal to depict the current situation. In contrast, figures from PDHS 12/13 were used for the EPE to depict the status of the three preceding years. As the project activities first began in 2012, these figures are more appropriate for the purposes of before-and-after comparisons. This explains why several targets were already exceeded when the project began.

It should be noted that the figures aggregated at provincial level are of somewhat limited significance for evaluating the project's effectiveness due to the size of the provinces and the associated attribution gap, Punjab with around 110 million residents and KP with around 31 million, but also for AJK (4 million) and GB (1.5 million). However, figures that are disaggregated further are not available.

It is plausible that the awareness-raising campaigns within the scope of the FC project contributed to positive developments in the Contraceptive Prevalence Rate. It improved in KP, particularly in rural areas. An increase was also seen in GB. However, despite this increase, the rate continues to be low and it even decreased in the largest province of Punjab, thus the target was only achieved in two out of four provinces.

The Couple of Years of Protection (CYP) achieved throughout the entire project area by means of the contraceptives sold by the local NGO (social marketing component) is used as a proxy indicator of improved demand, access and use. The target of 2 million CYP was already exceeded by a significant amount at the time of the final inspection. However, using the CYP target to evaluate results is only suitable to a limited extent as the target was not adjusted to reflect the additional financing in phases II and III. The CYP target has not been monitored since the conclusion of the FC project. However, a sustainable increase in the sales numbers seems plausible as the points of sale continue to receive subsidized contraceptives financed by other donors.

To determine the success of the social franchising model, the development trend of the CYP in the clinics supported by the project is also taken into account within the scope of the evaluation. Over the course of the project, there is a trend towards positive development, particularly in rural and pilot clinics. The mobile health clinics that reached a large number of patients with treatments in remote regions temporarily made the greatest contribution to the CYP. When these clinics stopped operating at the end of the FC project, it

led to a significant reduction of the total yearly CYP achieved as of 2018. A further reduction in the figures in the rural clinics can be attributed to a supply bottleneck for a popular brand of copper IUD. The operators of the clinics also reported decreased demand for health services due to the COVID-19 pandemic.

Since the clinic in the Afghan refugee camp focused on other areas in addition to reproductive health services, the number of treated patients (women and children) is also used as an additional indicator here. The sharp upwards trend indicates that the offer was well used.

Support within the scope of the FC project benefited 450 existing clinics; 110 new clinics were created. In the random sample interviewed for the EPE[2] the franchise clinic operators indicated a high degree of satisfaction with the support from and cooperation with the local NGO; the training provided received particular praise. The contraceptive supply was also described aslargely uninterupted. The operators confirmed that local NGO staff regularly visited the clinics to monitor compliance with the quality standards for the services.

95% of the patients interviewed within the context of the EPE indicated a high or very high degree of satisfaction with the offers regarding health services and consultation and confirmed that the local NGO's clinics were their only option to access reproductive health services and contraceptives. However, the significance is anecdotal as the number of interviewed patients was low and the selection of interviewees was predetermined by the local NGO.

The interviewees indicated that they found the clinics' services in the northern provinces to be affordable. This corresponds with statements made by the clinic operators indicating that treatment fees are adjusted in line with patients' ability to pay, or even completely waived in some cases. However, these decisions were made at the sole discretion of the operators, which means there is a risk that patients could be excluded from services. The prices for a majority of the treatments in the clinic in the camp for Afghan refugees in Islamabad are viewed as affordable by the users surveyed, and medicines are provided free of charge.

During the implementation, fewer awareness-raising campaigns were carried out than originally planned (in favour of increasing the provision of more contraceptives, also see Efficiency). However, a study carried out by the local NGO in the project areas showed that, although the positive impacts of family planning were recognised by the majority of those interviewed, around one third continued to have significant reservations about contraceptives due to negative health effects, religious convictions or fear of infertility, among other factors.[3] The particularly high scepticism with regard to family planning among the Afghan refugees was met with outreach measures and the integration of religious leaders from the camp. However, according to statements from surveyed patients, this scepticism continues to be a main obstacle to the use of contraceptives.

The targets set at outcome level were exceeded in some cases but were not achieved in others. The impressions of the target group's change in attitude and behaviour with regard to the use of modern family planning methods collected within the scope of the EPE indicate that there continues to be a large unmet need for information and education, measures that were scaled back during the implementation. Despite the affordability confirmed by the interviews, there is a risk to equal access. So, the effectiveness of the project is therefore rated as moderately successful overall.

Effectiveness rating: 3

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[2] Nine of the 100 newly built clinics were selected for interviews. The selection covered all programme regions and clinic types and was made randomly by the evaluation team. The clinic in the camp for Afghan refugees was also included in the random sample due to its central importance within the project. In total, ten clinic operators and 18 patients were interviewed. The local NGO facilitated the contact with the interviewees.

[3] For the study, 2,252 households in 24 tehsils (local administrative units) throughout the entire project area were surveyed.

Efficiency

From the point of view of allocation efficiency, the cooperation between established executing agencies should be deemed positive as the project was able to rely on the local NGO's existing structures. The organisation was already present in the project region, which significantly reduced efforts associated with identifying new clinic locations or with logistics for example.

The local NGO also has centralised procurement processes, and purchases contraceptives at low prices through competitive bidding, making the condom brand sold by the local NGO the most affordably priced product on the Pakistani market, for example. The only repeated bottleneck issues were the procurement of medicines for basic health care for the clinic in the camp for Afghan refugees, since the local NGO could not rely on established procurement processes, in contrast to the area of reproductive health.

In addition, the expansion of the project and the simultaneous implementation of phases II and III resulted in significant synergy effects, for example through the use of the same personnel by the local NGO, which also contributed to the project's efficiency.

The extent to which underserved population groups benefited from the contraceptives provided within the scope of the FC project, or whether these measures drew users away from public or other private providers, cannot be evaluated within the context of the EPE due to insufficient data. A coordinated total market approach could maximise the allocation efficiency here, but this was not implemented (also see Coherence).

Production efficiency was increased significantly over the course of the project. The costs per achieved CYP were reduced from PKR 674 to PKR 419, despite the expansion into remote regions, primarily due to the increase in contraceptive sales, and were thus lower than the average achieved by the local NGO overall in Pakistan as well as significantly lower than relevant benchmarks for the Asian region.[4] In addition, the share of sales revenue from contraceptives that contributed to the implementation costs of the local NGO rose markedly from 20% to 48%, which can be attributed to the increased demand and associated sales at the local NGO's points of sale. At the same time costs for training and awareness-raising measures were reduced significantly (see also Effectiveness).

In the clinics, the operators themselves ensured that treatments were implemented in a manner that covered costs. However, the interviews made it clear that it is not possible to finance larger renovation and maintenance work in some cases. By contrast, at the clinic in the camp for Afghan refugees they charge symbolic fees that do not cover the treatment costs. Although this is understandable due to the great needs of the target group, this aspect is critical with regard to operating efficiency.

The project was extended by a total of 2.5 years without increasing the costs. As this was mainly attributed to surplus funds from savings (e.g. lower costs for training and scaling effects) and not due to implementation delays, this is not a negative factor with regard to rating the efficiency.

The FC-financed portion of the project was used for direct project costs in particular, while the indirect costs were primarily covered by a counterpart contribution from the sales of contraceptives by the local NGO.

Due to the advantages of having an established executing agency and the increase in cost efficiency over the course of the project, the overall efficiency of the project is rated as good.

Efficiency rating: 2

Impact

The overarching development objective of the project was to contribute to improving the sexual and reproductive health and rights of poorer segments of the population (impact). No indicators at impact level were

[4] Compare with Rudner, Nicole (2012): Social Marketing- und Social Franchising-Ansätze zur Förderung von HIV-Prävention und Familienplanung, KfW Entwicklungsbank. (only available in German)

defined in the project proposal. So for the EPE, four new indicators were defined that depict the key developments in the areas of family planning and sexual and reproductive health in the regions concerned. Target achievement at the impact level is summarised in the table below:

Indicator	Region	Target value PA	Status at start of project (PDHS 2012/2013)		Status EPE (PDHS 2017/2018)	
			Total:	Rural	Total:	Rural
1. Fertility rate in the project region (children/woman)	KP	-	3.9	-	4.0	4.2
	GB	-	3.8	-	4.7	-
	Punjab	-	3.8	-	3.4	3.7
	AJK	-	-	-	3.5	3.6
2. Infant mortality rate in the project region (for 1,000 live births)	KP	-	58	59	53	57
	GB	-	71	-	63	-
	Punjab	-	88	96	73	77
	AJK	-	-	-	47	48
3. Maternal mortality rate in the project region (for 100,000 births)***	KP	-	275	-	165	-
	GB	-	-	-	157	-
	Punjab	-	227	-	157	-
	AJK	-	-	-	104	-
4. Average period between births (months) in the project region	KP	-	32.0	-	31.0	31.0
	GB	-	29.9	-	29.9	-
	Punjab	-	27.0	-	26.6	25.8
	AJK	-	-	-	29.3	29.3

***Due to lack of availability, the maternal mortality rate data were from PDHS 06/07 and the Maternal Mortality Survey 2019.

No information is available with regard to target achievement in the camp for Afghan refugees in Islamabad. The development of the indicators in the four provinces in northern Pakistan demonstrates a positive trend to some extent. There has been progress in the area of maternal and infant mortality in cases where reference values from the start of the project are available. This indicates improved health care overall, both in the public and the private sector, as well as better education with regard to prenatal and postnatal care. While it seems plausible that the FC project contributed to this positive development, realistically, its contribution is limited, particularly in the highly populated KP and Punjab regions (for limited validity of data at provincial level, also see Effectiveness).

By contrast, the sustained high fertility rate, which increased slightly in KP and significantly in GB over the course of the project, as well as the stagnating and in some cases reduced gap between births, is cause for concern. Extending the gap between births is associated with significant health improvements for mothers and children, and information on this topic was a key element of the awareness-raising measures. On the other hand, declining fertility rates are considered a key prerequisite for stabilising or reducing population growth, and this, accompanied by educational and employment measures for young people, would generate demographic dividends. To reduce the number of births in the long term, however, further expansion of the family planning services would be needed in addition to economic development and a cultural transition with regard to the position of women, supported by political and religious institutions.

Despite the noted limitations, it is plausible to assume that the project contributed to improvements at the local level, particularly in the situation of women. In rural areas in particular, clinics are often the sole providers of advice and family planning services. The wide range of contraceptive methods enabled the FC project to improve the supply-side prerequisites for self-determined family planning. Support from the local NGO is a prerequisite for clinic operation in this process and contributes to a significant improvement in the range of services offered and their quality. These services can have a thoroughly transformative impact on the lives of women; fewer births with longer gaps in between have the potential to significantly improve women's health and educational opportunities and thus facilitate their increased participation in community and economic life.

Despite plausible improvements at local level and with regard to maternal and infant mortality rates, the project was unable to exert a positive influence on the development of the fertility rate and the amount of time between births at impact level. As the influence of the project on the overall situation in the project areas is only very limited, the impact is rated as moderately successful.

Impact rating: 3

Sustainability

Since the end of the promotion, several activities have continued to receive financing from the regular budget of the local NGO, while others have been scaled back due to limited funding. The clinics supported by the programme thus continue to receive subsidised contraceptives and can provide the same range of services. Visits from the local NGO's staff also continue to take place regularly for quality assurance purposes. However, the lack of a maintenance concept and budget continues to present a risk to the sustainable operation of the clinics. Several of the interviewed operators indicated that their facilities required renovation work that would require additional financial support. However, this has not been planned by the local NGO thus far.

The accompanying range of training measures and staff-intensive awareness campaigns in the areas surrounding the clinics was significantly scaled back when the promotion was phased out. However, the operators view these components core added value of the FC project. It is therefore to be feared that both the quality of the services and the demand for modern family planning methods could be negatively affected. The provision of mobile health services also stopped, which in turn halted important supply options, particularly in very remote regions. However, container clinics also operated by the franchisees were installed at six of the locations previously served by the mobile services to ensure a continued supply.

The clinic in the camp for Afghan refugees in particular demonstrated significant deficits with regard to sustainability. After the end of the FC project, this clinic continued to besupported by the regular budget of the local NGO but had to reduce its staff from nine to six employees on grounds of cost. To cover the steady high demand in the camp, the responsible doctor believes the clinic needs additional personnel and technical equipment. In addition, the long-term future of the refugee camp's current location and thus that of the clinic is unclear, and there is a risk that the government may relocate it. Closer contact with state authorities in this case may possibly have increased the planning security (see also Coherence).

The COVID-19 pandemic initially led to a decline in the number of people treated in the clinics. However, treatments continue in accordance with hygiene regulations, and it was possible to bridge temporary reductions in income, so the operators do not expect long-term negative effects on operations.

While regular operation of the clinics is ensured to a large extent, central programme components such as training and awareness-raising measures were reduced, and maintenance risks to long-term project success have not been completely eliminated. The sustainability of the project is therefore assessed as moderately successful.

Sustainability rating: 3

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

Projects are evaluated on a six-point scale, the criteria being **relevance, coherence, effectiveness, efficiency, overarching developmental impact** and **sustainability**. 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.

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).