KfW Development Bank

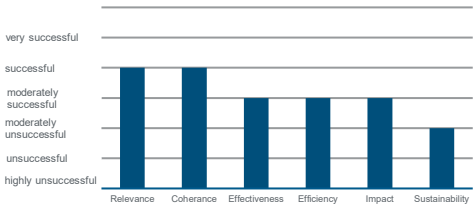
Ex post evaluation
Health programme for Gilgit-Baltistan, Pakistan

Title	Health programme for Gilgit-Baltistan		
Sector and CRS code	12220 – Basic health care		
Project number	2004 65 039		
Commissioned by	Federal Ministry for Economic Cooperation and Development		
Recipient/Project-executing agency	Ministry of Economic Affairs and Statistics / Directorate of Health Gilgit-Baltistan (DoH), international health NGO (int. NGO), local family planning NGO (FP NGO), local NGO for combating tuberculosis (TB NGO)		
Project volume/ financing instrument	EUR 4.55 million FC loan; EUR 2.94 million FC grant		
Project duration	2007 - 2017		
Year of report	2021	**Year of random sample**	2020

Objectives and project outline

At impact level, the target was to improve the health situation for the poorer population in Gilgit-Baltistan (GB). At outcome level, the target was to improve the target group's use of appropriate, quality health care services in basic health facilities, particularly by mothers and children, and strengthening the referral system. An approach with four executing agencies was chosen to do this – the public Directorate of Health (DoH), an international NGO that operates basic health facilities and hospitals (int. NGO) and two local NGOs active in family planning (FP NGO) and combating tuberculosis (TB NGO). All executing agencies were given support to improve their health infrastructure, particularly with equipment, and to strengthen staff capacities with training measures. In one hospital, a public private partnership (PPP) concept with the DoH and the int. NGO was piloted to strengthen cooperation.

Overall rating:
moderately unsuccessful



Key findings

A project visit was not possible due to COVID-19 travel restrictions. The evaluation is therefore based solely on the information provided by interviewed stakeholders within the scope of the remote evaluation and generally accessible data.

It is plausible that the FC project helped improve and expand health services in underserved areas (outcome) and thus contributed to improving the target group's health situation (impact).

- With the structural strengthening of the health sector in GB, a plausible approach was used to pursue an ambitious target. (Relevance)
- The private executing agencies (no data available for the DoH) increased the use of their services; however, there are still shortcomings with regard to the capacities of the DoH, the referral system and cooperation between the private and public sector (Effectiveness).
- The approach with four executing agencies as well as the associated coordination effort and parallel structures, including those used for procurement, among others, reduced the allocation efficiency; in addition, delays further affected the rating.
- At impact level, maternal and infant mortality rates were reduced; but the fertility rate in the region continued to rise, which is a significant constraint for development. (Impact)
- The measures' impact is only sustainable with regard to the int. NGO. For the other three executing agencies, it is limited due to financial constraints after FC financing ended. The lack of capacity for maintenance at the DoH is particularly critical in this regard.
- The project is rated unsuccessful due to the lack of sustainability.

Conclusions

- The creation of a master plan can be a useful starting point for coordination between the public and private sectors and for aligning projects and fill existing gaps in service provision.
- The lack of maintenance capacities at the DoH was temporarily cushioned using maintenance contracts; yet due to a lack of long-term financing, the sustainability remained limited. The private sector (int. NGO) has maintenance units; there coculd be potential for synergies.
- Structurally strengthening the health sectors in a context such as GB requires longer-term involvement and sustainable financing concepts to ensure access, quality, and affordability.

Rating according to DAC criteria

Overall rating: 4

Ratings:

Relevance	2
Effectiveness	3
Coherence	2
Efficiency	3
Impact	3
Sustainability	4

Relevance

The objective of the FC project was to improve the health situation of the poor population in Gilgit-Baltistan (GB). This region in northern Pakistan has been semi-autonomous since 2009, is part of the politically disputed region of Kashmir, and has around 1.5 million inhabitants today.

The infant and maternal mortality rates in GB were far above the Pakistani average at the beginning of the FC project.[1] Communicable diseases such as diarrhoeal diseases, respiratory infections, tuberculosis (TB), and preventable childhood diseases made up most of the disease burden and causes of deaths. Although the unmet need for family planning for unmarried women of childbearing age has gone down significantly in recent years, in 2017 it was still 26 % in GB in comparison to 17 % at the national level. This also contributes to the region having one of the highest fertility rates in the country (4.7 children/woman in GB compared to 3.6 children/woman in Pakistan overall, PDHS 2017/2018), which is considered a significant constraint for economic and social development.

At the time of the project appraisal, the public health sector in GB was and continues to be severely underfinanced, but at the same time, it is the main provider of health services, which it usually provides free of charge. This public service is supplemented by private healthcare providers, who often have a better reputation, but they have inconsistent quality standards and usually charge fees. One of the major challenges in the health sector in GB is insufficient health service coverage, primarily in the rural mountain regions that are difficult to reach, the lack of equipment in hospitals and a general lack of medical professionals (one doctor per 4,100 inhabitants compared to a national average of 1:1,206 in Pakistan in 20122). The key challenges were correctly identified, and the selection of the intervention area continues to seem reasonable ex post.

The results chain is plausible. By improving access to basic health facilities run by both public and private executing agencies, and strengthening the referral system, the FC-financed measures were aimed at increasing poorer population groups' use of appropriate and efficient health care in GB, particularly by mothers and children (outcome). One particular focus of the measures was on improving the areas of family planning and tuberculosis treatment. The aim was to enhance the health of poorer population in the project area (impact) by increasing the use of improved health services. A master plan for the health sector in GB created at the beginning of the implementation together with public and private partners was the basis for the cooperation and the focus for the expansion of health services. FC-financed measures aimed to improve infrastructure and equipment in public and private health facilities and strengthen staff

[1] Maternal mortality at the beginning of the project was estimated at 600/100,000 live births compared to 276/100,000 nationally; infant mortality at the beginning was estimated at 122/1,000 live births compared to 78/1,000 nationally (Pakistan Demographic and Health Survey 2006/07)

[2] However, according to more current figures, despite the fact that the situation in GB has adjusted to the Pakistani average, it continues to be significantly lower than the WHO recommendation of 4.45 doctors per 1000 people (source: Pakistan Human Resource Health Vision 2018–2030)

capacities through training etc.To promote cooperation between the public and private health sector, a pilot project consisting of a hospital with a Public Private Partnership (PPP) concept was also implemented.

As a whole, the planned activities were suitable for addressing urgent supply gaps and structural weaknesses in the health sector in GB.

The immediate target group of the poorer population continues to be relevant from an ex post perspective, and should be addressed, particularly by strengthening rural health infrastructure. The focus on family planning and TB is also reasonable in view of the described health situation in the project area. The executing agencies were the GB Department of Health (DoH) in the public sector and, while in the private sector, they consisted of three non-governmental organisations (NGOs): one international NGO that operates both basic health facilities and hospitals in the project province (int. NGO), one local NGO specialising in family planning (FP NGO) and one NGO specialised in combating TB (TB NGO) (immediate target group).

Even though cooperating with four executing agencies comes with higher project complexity, it is plausible. Including and strengthening the DoH was essential since the public health sector in GB plays a vitally important role, while political support in the volatile project region was a major prerequisite for the success of the project. The int. NGO is the most important private actor in the health sector of GB and enjoys a high level of trust from the population due to the good quality of the services it offers. For their part, the FP NGO and TB NGO have considerable expertise in their respective priority areas (family planning and combating TB) and both were embedded in remote areas of the region as well. The challenging process of coordinating four executing agencies was taken into account when the project was designed by creating the role of the implementation consultant.

The project is consistent with the Pakistani government's health targets and with the German development cooperation sector strategy adopted in 2013 in the Pakistani health sector. The FC project is also a specific element of the regional health strategy of the provincial government in GB and covers its priorities in many respects.

The relevance is rated in line with expectations as "successful".

Relevance rating: 2

Coherence

The project is part of the DC programme "Support for health system development in Pakistan", which aims to facilitate access to high-quality and affordable health services for poor and vulnerable groups, in particular. It is the only project with a sole focus on the underserved GB region.

There were potential synergies with the FC project "Rural Family Planning" (including BMZ-No. 2009 66 150), which also promoted – in terms of both supply and demand – the usage of health services regarding reproductive health and family planning in GB through a different local NGO and its network of franchise clinics. Within the scope of the EPE, there were no indications of coordinated market coverage with contraceptives corresponding to a total market approach. There is no information available concerning any interaction between the project partners from different FC projects.

Furthermore, synergy potential was realised to some extent with the FC project "Healthcare financing" (BMZ-No. 2009 66 168). Within the scope of the mentioned project, support was provided for the introduction of health insurance for the population below the poverty line in Khyber Pakhtunkhwa (KP) and GB. The insurance covers a broad range of in-patient medical treatments that include obstetrics and surgical procedures (including in the int. NGO's facilities), as well as patient transport among others. Some of the services provided by the local NGO's are also integrated into the insurance system and there are plans to expand this further in the future.

The process of creating a master plan for the health sector in GB and the coordination between the four project-executing agencies during implementation of the FC project should be rated positively from a coherence perspective. According to statements, the DoH and the int. NGO are currently coordinating measures that include combating COVID-19 and using the facilities promoted by the FC project for vaccinations and treatment.

Due to the politically sensitive situation, other donors in the region are less present, so there was no overlapwith other initiatives in the health sector and thus no coordination took place.

The coherence is rated in line with expectations as "successful".

Coherence rating: 2

Effectiveness

The target at outcome level was to increase poorer population groups' use of appropriate and efficient health care in GB, particularly by mothers and children, through strengthening basic health facilities and the referral system.

At project appraisal, the respective Contraceptive Prevalence Rate (all methods3) was defined as an indicator at provincial level. For the EPE, the relative change in the prevalence rate of modern methods4 over time is applied as the state of the art indicator. Further indicators were defined at outcome level within the scope of the EPE based on the data provided by the executing agencies. However, it was not possible to determine targets for these indicators ex post (meaning that an increase is deemed positive here). Evaluating the effectiveness of the FC project was challenging due to an insufficient availability of data and the limited responsiveness of executing agencies, primarily in the public sector. No indicators were defined for measuring improvements in the referral system, and there are no meaningful data in this context. No quantitative data were provided for by the DoH within the scope of the EPE. Hence the outcomes achieved here are evaluated purely qualitatively, limited to interviews and document analysis, which reduces their informative value.

The target achievement at outcome level is summarised in the table below.

Indicator[5]	Status PA	Target value PA	Status at final inspection	Status EPE
(1) Contraceptive Prevalence Rate of modern methods in GB	28.2 % (2012) 27 % (health master plan)	-- 33 % (all methods)	--	30.2 % (PDHS[6] 17/18) 39 % (all methods, PDHS 17/18)
(2) int. NGO: Bed Occupancy Rate of the supported hospitals in GB	45-82 % (2009)	n/a	71-91 % (2017)	45-70 % (2020)
(3) int. NGO: in-patient treatments in GB	8,444 (2009)	n/a	11,541 (2017)	11,150 (2020)
(4) int. NGO: outpatient care in GB	297,464 (2009)	n/a	320,629 (2017)	340,374 (2020)

[3] "All methods" also includes so-called natural methods such as abstinence during the days of women's menstrual cycle when they are fertile, which are determined using techniques including temperature methods or birth control chains, among others.

[4] "Modern methods" comprise hormonal and mechanical contraceptives, including condoms, pills, IUDs, diaphragms, implants, etc. that are highly reliable according to the Pearl Index.

[5] Source: the figures were reported by the respective executing agencies themselves.

[6] Source: Pakistan Demographic and Health Survey.

(5) FP NGO: number of patients treated in GB	39,301 (2007)	n/a	300,568 (2017)	491,555 (2020)
(6) FP NGO: CYP achieved through the sale of contraceptives in GB	9,881 (2007)	n/a	47,693 (2017)	52,663 (2020)
(7) TB NGO: diagnosed cases of TB in GB	2,799 (2007)	n/a	2,613 (2017)	2,055 (2019)
(8) TB NGO: TB treatment success rate in GB	91 % (2007)	n/a	97 % (2017)	98 % (2019)

The private actors primarily implemented the measures in the FC project as planned, which resulted in a positive development of the outcome indicators. So, it is plausible that the measures, particularly with regard to family planning and reproductive health, made a positive contribution to the development of the Contraceptive Prevalence Rate of modern methods in GB[7]. The FP NGO was thus also able to noticeably increase the number of patients treated through the expansion of a Family Health Hospital and increase the Couple Years of Protection (CYP) by a significant amount.

The int. NGO increased the number of hospital admissions and outpatient care and achieved a relatively high Bed Occupancy Rate of over 70 % in the hospitals which, according to interviews, only slightly declined due to the COVID-19 pandemic.

The number of TB treatments performed by the TB NGO remained relatively constant over the course of the project. On the one hand, this can be attributed to the fact that some of the affected groups are located in remote regions, which remain difficult for the outreach teams to access. In addition, several stakeholders gave corresponding reports stating that the incidence of TB had declined in GB, but there are no official figures to confirm this. The treatment success rate increased over the course of the project, and at 98 % it is now far above the Pakistani average, which the TB NGO attributes to further training of medical professionals, in particular.

Within the scope of the FC project, the public sector reported that it was able to improve its health services in the project area both quantitatively and qualitatively thanks to improved equipment for delivery rooms at the second level of district hospitals and civil hospitals, among other things. Furthermore, the DoH reported that medical and administrative personnel participated in training within the scope of the project, which played a role in strengthening staff capacities. However, within the scope of the EPE, interviews, various stakeholders indicated that considerable weaknesses continue to exist with regard to the DoH's capacities.

Due to improved equipment and training in the promoted hospitals, qualified personnel can now perform more complex medical examination and treatment, which prior to the projectrequired a journey to the capital Islamabad. As treatment in the capital was not financially possible for the majority of the population, the FC project thus contributed to expanding the accessibility of a broader range of health services. According to reports the equipment is used intensively, but no information is available with regard to diagnostic quality and thus the appropriateness of the health care services. According to statements from various interviewees the quality of the treatments in basic health facilities improved, particularly due to the training of "Lady Health Workers" . In addition, interviews conducted within the scope of the EPE provided

[7] The target at the time of the appraisal related to "all methods" and was even clearly exceeded at 39%.

anecdotal evidence indicating a significant increase in acceptance of family planning services. A positive public sector contribution is plausible for the outcome objectives.

According to information from DoH interviewees, the referral system benefited primarily from the repair and procurement of ambulances, from public facilities' expanded range of treatments, and the informal networking of health personnel that was promoted through joint training modules. However, private facilities are still not integrated adequately into the referral system. It was not possible to determine whether the structure of the referral system was strengthened within the scope of the EPE.

According to the int. NGO, the DoH did not meet its contractual financial obligations for the hospital operated as a PPP together by the int. NGO and the DoH. These include, among other things, financial contributions for electricity costs and the subsidisation of selected health services that the int. NGO offers at low (not cost covering) prices. Instead, the DoH supported the hospital in kind but supplied deficient drugs. For this reason, the int. NGO is considering becoming the sole operator of the hospital in the future, which would result in fee increases, among other changes. The PPP pilot was thus rated as unsuccessful at the time of the EPE.

The mix of various executing agencies was partially able to compensate for the target group's low ability to pay. The DoH, FP NGO and TB NGO do not charge any fees, or only very low ones, and in some cases patients are treated even if they cannot afford to pay for the fees.. The int. NGO on the other hand charges treatment costs in its facilities, which could exclude particularly poor patients from treatment. Although fees are waivedin emergency cases, despite several requests there is still no information available within the scope of the evaluation about a formalised procedure for access of patients unable to pay. The anecdotal evidence collected within the scope of the EPE from interviews with a random sample of patients from the int. NGO's, FP NGO's and TB NGO's facilities indicate consistently high satisfaction with the quality and affordability of the rendered services.[8] Several of the patients interviewed within the scope of the EPE also used the health insurance to cover the treatment costs of the int. NGO (also see Coherence). However, in view of the effectiveness, it should be noted, critically, that when compared to the other executing agencies, the measures implemented with the int. NGO and accounting for around 1/3 of the total project financing possibly only benefited the project's target group to a small degree.

While the outcome indicators suggest a positive development in the use of improved medical services, insights gained within the context of the EPE continue to indicate clear deficiencies regarding the capacities of the DoH and the cooperation between the public and private health sector in the referral system. The extent to which the target group of the poor population benefited from improved access within the scope of the FC project cannot be conclusively evaluated, particularly for urban hospitals and the int. NGO's facilities. The effectiveness is therefore rated as moderately successful.

Effectiveness rating: 3

Efficiency

The fact that existing capacity in the health sector was identified within the scope of the master plan at the beginning of the project can initially be evaluated as positive, both with regard to production efficiency and allocation efficiency. However, for the EPE, there is no information about the actual use of the master plan for making investment decisions within the scope of the FC project (also see Sustainability).

Implementation through four different executing agencies resulted in inefficiencies and the use of different procurement channels, as well as significant coordination efforts. Better coordinated and thus more efficient interaction as a result between the public and private executing agencies in the referral system cannot be confirmed within the scope of the EPE (also see Effectiveness). It also seems that a coordinated total market approach in the area of contraceptives, which would have been able to maximise the allocation efficiency in the area of family planning for GB, was not implemented (see also Coherence). It was

[8] Within the context of the EPE, interviews were conducted with personnel from two of the int. NGO's hospitals, two of the FP NGO's facilities and one tuberculosis centre. The selection covers various facility types and executing agencies and was made based on the facilities' relevance for the project. In addition, 22 of the facilities' patients were interviewed, including nine from the int. NGO, ten from the FP NGO and three from the TB NGO.

possible to create synergy effects through joint training sessions to some extent. However, the overall view indicates rather limited allocation efficiency.

The DoH procurement system was strengthened with support from an external consultant, so the equipment for DoH facilities in the context of the FC project was acquired using competitive national and international bidding. The private executing agencies organised procurement using their respective headquarters outside of the region and were thus able to access established structures and to some extent realise scaling effects within their organisations. Beyond these indications, there is insufficient information to evaluate the production efficiency of individual executing agencies.

Over the course of the FC project there were repeated delays, so the project duration more than doubled from nearly five to over ten years. Negotiations with the central government about the disbursement modalities already caused significant delays at the beginning of the project. Constant administrative shortcomings at the DoH and changes of staff in the “Secretary Health” position that in some yearshappened several times a year also led to repeated long delays over the course of the project.

There is not enough information to evaluate the operating efficiency within the scope of the EPE. The int. NGO achieved a cost recovery ratio of over 80 % in the hospitals and 50 % in the basic health facilities through treatment fees. There is no information with regard to the cost recovery ratio for the facilities of the DoH, FP NGO and TB NGO. The public sector, in which no or very low fees are charged, is affected by financing constraints, as demonstrated with the PPP hospital example(see also Effectiveness and Sustainability). The FP NGO charges low or no fees in its facilities and is not able to pay its staff competitive wages, which leads to high staff turnover. The wages of the TB NGO’s staff are covered by the government. Sustainable financing remains challenging, particularly for the DoH, the FP NGO and the TB NGO and, to a lesser extent, also for the PPP with the int. NGO (see also Sustainability). Within the context of GB, the financing cannot be achieved through cost-covering user fees as this would exclude large parts of the population from access. It instead relies on other sources (donor funds, budgetary allocations or, if possible, reimbursements under health insurance) (see also Effectiveness and Sustainability).

Due to limitations in allocation efficiency and time efficiency, the overall efficiency of the project is assessed as moderately successful.

Efficiency rating: 3

Impact

At impact level, the FC project aimed to improve the health situation of poorer population groups in GB. The target achievement can be summarised as follows:

Indicator	Status PA	Target value PA	Status at final inspection	Status EPE
(1) Maternal mortality rate in GB (per 100,000 live births)	600 (1998/99, reported in the health master plan)	60 % reduction (final inspection)	450 (PDHS 2012/13), 25 % reduction	157 (MMS[9] 2019), 74 % reduction
(2) Infant mortality rate in GB (per 1,000 live births)	122 (1998/99, reported in the health master plan)	60 % reduction (final inspection)	71 (PDHS 2012/13), 42 % reduction	63 (PDHS 2017/18), 48 % reduction
(3) Fertility rate in GB	-	-	3.8 (2012/13)	4.7 (PDHS 2017/18)

[9] Source: Pakistan Maternal Mortality Survey

(4) TB case notification rate in GB	214/100,000 (NTBCP[10] 2009)	-	216/100,000 (NTBCP 2016)	277/100,000 (NTBCP 2019)

The values reported at project appraisal with regard to maternal and infant mortality rates are from a 1998/99 survey (more recent data not available) and can thus only be compared with data from newer surveys to a limited extent.

The impact indicators have largely developed favourably. The data provided at the project appraisal for the maternal and infant mortality rates were already very outdated. However, it can be assumed that the figures in GB have declined considerably since the implementation of the FC project began. They are now below or at the level of the Pakistani average (maternal mortality rate 186/100,000; infant mortality rate 62/1,000). A survey conducted by the int. NGO in the area served by its facilities also showed improvement in infant or maternal mortality over the course of the project.[11]

The case notification rate for TB cases rose dramatically, primarily in the last few years, and has since become the highest in Pakistan. As there is no indication of a higher rate of TB infection in the region and there is actually a suspected decrease and the case detection rate is also the highest rate in Pakistan by far, it can be inferred that this indicates progress made in identifying TB cases. It seems plausible that the FC project made an important contribution here.

By contrast, the high fertility rate has further increased in recent years and now, along with the previous "Federally Administered Tribal Areas" (FATA), it has the highest rate in all of Pakistan (national average 3.6 children/woman). The success concerning the Contraceptive Prevalence Rate has not had an impact on the fertility rate. There are many reasons for this, ranging from socio-cultural norms, which change only slowly, to the desire for sons, through to very short times between births or errors when using contraceptives, which indicate that there continues to be a great need for raising awareness.

The impact of the FC project is rated moderately successful due to the increased fertility rate.

Overarching developmental impact rating: 3

Sustainability

While the int. NGO is able to continue operating its facilities, the FP NGO and TB NGO, according to statements made during the EPE, had to scale back their particularly cost-intensive activities after the FC promotion ended. This particularly affected the FP NGO's awareness-raising measures in remote regions of GB, which were reduced at the end of the FC project. In the long term this could adversely affect success with regard to acceptance of family planning, particularly in rural areas (see also Impact).

According to interviews, the TB NGO also scaled back its involvement in awareness-raising measures. The facility-based DOTS strategy for combating TB implemented by health personnel[12] within the scope of the FC project can no longer be implemented by the TB NGO in GB for cost reasons. According to information provided by the TB NGO under the EPE, the monitoring of medication intake as defined by DOTS is now ensured by members of the household. The TB NGO stated, a lack of sufficient funds for visiting patients. The extent to which the limitations of the TB NGO's involvement affects risks with regard to the spread of TB and multi-resistant strains of TB cannot be conclusively evaluated within the scope of the EPE.[13]

[10] Source: National TB Control Programme

[11] According to the survey conducted by the int. NGO, the infant mortality rate between 2009 and 2016 improved from 22/1,000 live births to 18/1,000 live births. Maternal mortality improved from 83/100,000 live births to 25/100,000 live births.

[12] The DOTS strategy was introduced by the WHO in 1994 to combat TB and comprises a combination of management and technical components, which include aspects related to the diagnosis and standardised treatment of positive cases monitored by medical personnel, also with regard to the monitoring/reporting of cases and ensuring uninterrupted availability of TB medication, among other things.

[13] Source: WHO (2020): Consolidated guidelines on tuberculosis.

The training measures for medical personnel implemented within the context of the FC project were only partially institutionalised by the project-executing agencies. While the int. NGO established a training programme, the other executing agencies highlight the urgent need for further support to continue the training. The DoH's improved capacities seem to be limited primarily to a cohort of staff members who participated in administrative training sessions under the project. Within the scope of the EPE, the DoH staff members mentioned the creation of a new master plan, but a draft was not made available, so it is not possible to make a conclusive assessment of the quality and benefits for further development of the health sector.

An additional high risk to the sustainability of the project's impacts lies in the lack of maintenance of medical equipment, particularly in the public sector. Based on experience from the first project phase, this was taken into account when the project was designed, and a five-year guarantee was agreed with suppliers. However, the interviewed DoH staff members indicated that equipment malfunctions and breakdowns have become more frequent since the guarantee expired. While the int. NGO employs technical teams to maintain equipment in its hospitals, the DoH was unable to establish maintenance units due to a lack of qualified personnel and financial resources. Upon the expiration of the guarantee, it seems that adequate maintenance of the equipment financed within the scope of the FC contribution is not ensured in the public facilities (amounting to around 46 % of the FC contribution, around 57 % of the total contribution). The extent to which an expansion in health insurance could contribute to solving the financing problem, particularly with regard to maintenance, cannot be evaluated within the scope of the EPE (also see Coherence).

During the EPE, no private executing agencies reported limitations regarding the provision of drugs and contraceptives after conclusion of the FC projects. However, sustainable financing is uncertain to some extent in view of the funding shortfalls reported (e.g. by the FP NGO and TB NGO). Factors including reports from the int. NGO within the context of the PPP hospital give rise to doubts as to whether the supply of drugs is ensured in the public sector in the long term.

In short, the FC project demonstrates clear shortcomings concerning the sustainability. Activities relevant for the impact, such as training and awareness-raising campaigns about family planning and TB, only take place to a limited extent at the time of the EPE due to a lack of financing. Without specific prospects for the financing of a maintenance concept, the limitations with regard to the use of financed equipment in public-sector facilities – that were already apparent at the time of the EPE – also indicate reduced effectiveness in a considerable portion of the FC-financed measures. Except for the measures implemented with the int. NGO, the sustainability of the total project is therefore rated as moderately unsuccessfull.

Sustainability rating: 4

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).