Ex post evaluation – South Africa

Sector: Prevention and control of sexually transmitted diseases and HIV/AIDS (13040)
Project: HIV prevention through voluntary counselling and testing I BMZ no. 2002 66 064*
Implementing agency: Development Bank of Southern Africa (DBSA)

Ex post evaluation report: 2017

		Planned as of appraisal	Actual
Investment costs (total)	EUR million	11.25	9.29
Counterpart contribution	EUR million	2.25	0.51
Funding	EUR million	9.00	8.78
of which BMZ budget funds	EUR million	9.00	8.78

*) Random sample 2016

Summary: The project was structured as an open programme intended to contribute to HIV prevention. The FC grant of EUR 9 million was used for expanding and improving the infrastructure for HIV tests and counselling services in 207 public health facilities. Furthermore, communication measures for awareness and education about testing and counselling provision were implemented, and consulting services funded to support the implementing agency.

Development objectives: The overarching development objective (impact) of the project was to contribute to slowing the increasing HIV infection rate, and enable better care and treatment for those infected with HIV.

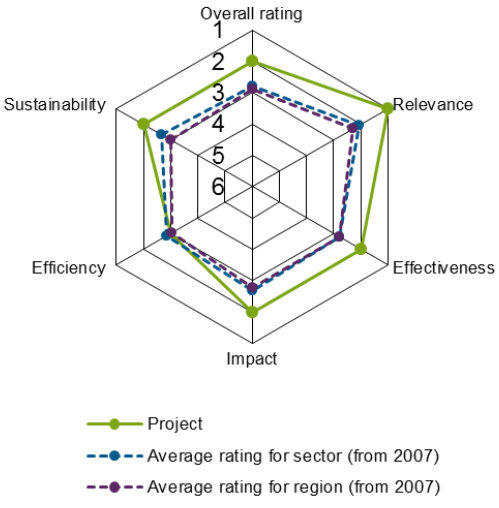
The project objective was to improve the population's access to HIV tests and counselling services, to improve the quality of HIV tests and counselling services in selected areas, as well as to educate the population about HIV/AIDS and sexually transmitted diseases (STDs).

Target group: The project's target group was the sexually active population in particularly disadvantaged regions of the three target provinces: Eastern Cape, KwaZulu Natal and Mpumalanga.

Overall rating: 2

Rationale: The project was consistent with national and international priorities in a public health crisis, as well as with the local needs. It was "the right approach at the right time". The efficiency of the six-year implementation period did not completely meet expectations. However, results show that the number of HIV tests and counselling services was effectively expanded and the quality of the services was improved. The good development of the sectoral context enabled a sustainable achievement of the overarching development objective.

Highlights: The evaluation discussions at the project sites demonstrated much more diverse positive effects than expected from the infrastructure measures implemented. For example, in addition to the physical results, the investments also provided a line of argumentation for increasing personnel budgets, more motivation for existing personnel, and they grabbed the attention of the population and decision-makers, especially in locations where local stakeholders were included early on in the course of the project.



Rating according to DAC criteria

Overall rating: 2

Relevance

At the time of project appraisal in 2002, the HIV/AIDS epidemic in South Africa was spreading at an alarming rate. The first significant national estimates showed an annual rate of new infections (incidence) of 2.7% of the population and a proportion of HIV-infected individuals (prevalence) of 16.2% of 14–49-year-olds for 2005. More than a third of people in certain segments of the population were already affected at that time. At the same time, 62% of women and 72% of men had never had an HIV test and were thus unaware of their HIV status.[1] Hundreds of thousands of deaths per year, political pressure from the international community and civil court cases initially brought the South African government to the realisation that HIV/AIDS is "the most important challenge facing South Africa since the birth of our new democracy"[2]; the government then set relevant political priorities in National Strategic Plans and implemented increasingly consistent countermeasures starting in 2004. It was possible to increasingly decentralise HIV Counselling and Testing (HCT) at this time due to the availability of quick tests and integration of specifically trained "HIV lay counsellors". The first national awareness and mobilisation campaigns took place in parallel with this. In 2004, treating HIV with antiretroviral medications (ARVs) was still ramping up under medical supervision in large hospitals. Starting in 2007, this was gradually rolled out in the smallest clinics, similar to the development that took place with the testing methods.

The assumed interrelationship between HCT and a reduction in the rate of new HIV infections during the project appraisal is plausible: ideally, knowledge about one's own HIV status in conjunction with counselling leads to a reduction of sexual risk behaviours of all people tested. In this case, HCT is the necessary condition for ARV treatment of people who tested positive, which also has a significant preventative effect due to the reduction of the viral load.

The HIV epidemic and the described countermeasures significantly changed the requirements on the physical health infrastructure and made adaptation investments urgently necessary. In most cases, the already heavily strained public health facilities were not equipped with enough dedicated rooms of sufficient quality to perform HIV tests and counselling at the beginning of the project. The social context was characterised by the population's lack of knowledge, scepticism due to counterproductive statements made by the President at the time, and by similarly significant fears and stigmas regarding HIV/AIDS. On the one hand, this meant that the existing trust in public health facilities was a valuable basis for expanding HCT. On the other hand, this context made the issue of ensuring privacy an important criterion for HCT quality. As per the evaluation discussions, the reality before the project began was that many tests and counselling appointments were conducted in laundry rooms, washrooms or outside. As a result, (potential) patients were lost because they had to wait a long time or the counsellors were hard to find. Especially in rural regions, transport routes and costs often impeded people from taking advantage of alternative appointments. In view of these challenges, the main approach of investing in dedicated physical infrastructure for HCT in public health facilities was consistent with the national priorities and the local needs of the target group. It was a fundamentally relevant, plausible approach to HIV prevention. According to the evaluation discussion, it was "the right approach at the right time".

The approach was practically integrated into dynamic sector development and, despite many similar NGO and donor initiatives (Global Fund, PEPFAR, TAC, UNAIDS, US CDC and many more) and complementary involvement of GIZ, it was possible to avoid duplicate efforts. Multisector coordination committees at all political levels ensured satisfactory coordination and alignment of national and donor-financed HIV countermeasures. On an overarching level, the project explicitly complied with the sixth Millennium Development Goal (combat HIV/AIDS, malaria and other diseases) at the time and is also in line with the current third Sustainable Development Goal (ensure healthy lives and promote well-being for all at all ages).

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[1] Demographic and Health Survey 2003, Dept. of Health, 2007

[2] HIV/AIDS & STD Strategic Plan for South Africa 2000-2005, Dept. of Health, 2000

The establishment of HIV prevention as a focus area for German-South-African development cooperation since 2010 and the confirmation of this focus area in 2015 also highlight the fact that this was and is a high-priority project for cooperation of both countries.

Overall, the relevance of the project is exceptionally high due to the urgent need and its integration into a systematically implemented sectoral approach.

Relevance rating: 1

Effectiveness

The project objective was to improve the population's access to HCT[3] and to improve the quality of HCT services in selected areas, as well as to educate the population about HIV/AIDS and sexually transmitted diseases (STDs). As the project was being developed and appraised, the focus of the Theory of Change and the projects was already clearly on increasing the number and quality of HIV tests and counselling services. This focus on using HCT also follows the ex post evaluation.

During project appraisal, utilisation of the HCT capacity created was defined as an indicator yet to be specified. Taking the project focus and data situation into account, the number of HIV tests in target provinces' public health facilities is defined as a specific indicator during evaluation to measure use of the infrastructure created.

The achievement of the project objectives can be summarised as follows:

Indicator*	Status before project implementation (2004)	Target value**	Status after project implementation (2010)
Number of HIV tests per target province per year			
Eastern Cape	117,510	217,510	898,989
KwaZulu Natal	157,670	257,670	1,686,510
Mpumalanga	28,595	128,595	1,060,247

Data source: Health Information System, HIV Directorate, NDoH

* During appraisal: capacity/utilisation, adjusted by the evaluation mission

** Defined by the evaluation mission according to assumptions during the appraisal: 50 sites per province x capacity for 1 additional counsellor per site x 10 HCT sessions per counsellor per day x 200 counselling days per year = 100,000 additional sessions per year

The number of annual HIV tests in the target provinces increased by twelve times during the project period. The proportion of the population that took advantage of HIV testing rose substantially, representing 60% in the target provinces in 2012.[4] An effective contribution of the financed infrastructure measures to increasing the number of HIV tests in the target provinces is probable. However, it must be seen within the context of numerous additional conditions. There are considerable interdependencies between factors such as personnel and material availability, and the development of HCT demand within the population. Due to the numerous parallel initiatives and projects targeted at these general conditions, and due to the limited extent of the project (207 of around 1,800 clinics in the target provinces), it is not practical to directly establish the effectiveness of the project from the overall development of the indicator values.

In view of the financing volume and the physical "output", an increase of 100,000 annual tests in each of the three target provinces can nonetheless be defined (see above for the derivation**). The number of

[3] Commonly used term at the time: "voluntary counselling and testing" (VCT), today part of the general concept of HCT

[4] Republic of South Africa: South African National HIV Prevalence, Incidence, Behaviour and Communication Survey 2012. This survey had not been conducted at the time of the project appraisal. According to the Demographic and Health Survey, only approximately 30% of the population in the target regions had been tested for HIV in 2003.

tests carried out in the target provinces that was actually achieved at the end of the implementation period exceeded the minimum expectation by far. It is therefore clear that the secondary conditions and interdependencies listed did not prevent target achievement, at least. Insofar as individual specific data for the project sites before and after implementation of the project are available, they highlight the contribution of the project to development at the province level, with proliferation of the number of tests performed during the year after local implementation in some instances.

In addition, the following qualitative insights of the evaluation shall serve to assess the plausibility of the specific contribution of the project to quantitative and qualitative project objective achievement.

An improved level of provision of HCT services was the necessary basis for the rise in the number of HCT service users. Overall, an effective increase in HCT provision as a result of the project is plausible. The number of upgraded clinics was far above the conservative target at the time of project appraisal (207 clinics achieved instead of the planned 150). According to available data and site visits, all project sites have provided ongoing HCT services since project implementation. They usually continue to be offered by specialised lay counsellors in the rooms built specifically for this purpose.

Against the backdrop of widespread staff shortages in the South African health sector, a critical secondary condition for the effectiveness of the project is the availability of appropriate personnel, especially in rural public facilities. The increasing use of specifically qualified HIV lay counsellors starting in 2004 made a critical contribution in the target facilities so that the created infrastructure could be used as intended in most cases. These counsellors were often financed outside of the regular clinic budget, also by donors or NGOs in some instances. According to participants, the project provided a "platform that we could also use to apply for funds to pay counsellors".

According to consistently positive statements, the quality of HCT services was also effectively improved by the project, in particular by means of shorter waiting times and by taking the privacy of the users into account. During the project appraisal, ensuring privacy was a key requirement for implementing the project. When drafting the project guidelines, the advantages and disadvantages of various HCT approaches were carefully weighed with regard to stigma and privacy. The project locations implemented the guidelines extensively, also thanks to the nationally introduced HCT quality standards from the Department of Health before implementation began. Contrary to the guidelines and the demands of local personnel, separate HCT buildings (instead of integrated rooms) were built at individual sites. A rough interim evaluation by the consultant revealed an overall increase in perceived HCT service quality and improved user satisfaction for 77 sites.

In addition to improving provision, it is plausible that the project also contributed to an increase in demand for HCT services from the population reached by public clinics. According to clinic personnel, the improved HCT quality contributed significantly to increased use of the services, both by increasing the number of first-time users and reducing the number of "losses" after initial contact. The improved ARV availability starting in 2004 also motivated those interested in tests. In the event that they tested positive, they could increasingly anticipate faster treatment and would not have to wait until they reached a critical state of health. This made the problematic logic of "you only need a test if you feel bad" obsolete.

The contribution of the small marketing components of the project for local awareness and increased demand can hardly be evaluated in the context of the nation-wide mass campaign. However, their effects were apparently limited insofar as no one at these locations could remember these project components. Instead, it was the construction measures themselves that generated local attention in the population and among local decision-makers. However, as expected during the appraisal, the public facilities only reached about a third of men and did not reach enough adolescents or itinerant high-risk groups (e.g. migrant workers, miners, truck drivers, prostitutes). The decision at the beginning of the project to not also finance NGO facilities that more intensely address specific risk groups due to the high need for investment in public facilities limited the effectiveness in this sense. On the other hand, focusing on the public health facilities made it possible to simplify the execution structure and reinforce the economies of scale in implementation.

In summary, we assume that the project made a considerable contribution to achieving the project objective. The effectiveness of the project was good overall.

Effectiveness rating: 2

Efficiency

The total costs of the project were EUR 9.29 million. The estimate during project appraisal that the South African counterpart contribution would include up to EUR 1.7 million for personnel was not followed up. However, the sites certainly benefited from appropriated government subsidies in an unknown amount specifically for HIV/AIDS prevention. Without these personnel costs, the total costs were below the estimate during appraisal.

The investment costs of EUR 6.73 million were only slightly above the estimated costs and were essentially used in construction measures for creating dedicated HCT spaces in public clinics and, in small part, also to furnishing these rooms. A KfW mission performed a detailed analysis of construction quality and costs in 2013 in a random sample of 43 project sites. At ZAR 7,650 per m² on average, the construction costs were higher than usual for the area (ZAR 5,600 per m²) and also higher than expected during the appraisal (up to ZAR 6,000 per m²). This is partially due to delays, inflation and the rural focus of the project, with some of the sites difficult to access, which are reflected in higher transport and material costs. Outliers with costs of over ZAR 15,000 per m² suggest individual failings when awarding the contracts and during construction supervision, which did not ensure efficient use of funds at all sites. Overall, the cost efficiency of the construction measures was also satisfactory after taking the rural sites and construction quality into account.

Costs of EUR 2.16 million for consulting services (23% of the total costs including the DBSA management fee) were high compared to the investment costs and higher than expected during the appraisal. However, due to the increased number of sites to be supervised, the number of project stakeholders to be coordinated and, in particular, in view of the long implementation period, this sum is still acceptable.

The effects and thus also the efficiency of the EUR 320 thousand in expenses for the project's marketing components are not detectable six years after conclusion (see "Effectiveness" section). The relatively low expenditures of EUR 80,000 for results monitoring correspond to the limited reliable results from the interim evaluation.

The implementation period of six years was twice as long as originally planned. In this sense, the efficiency of implementation was lower than expected. This stemmed from the need to set up a new project structure, delayed invitations to tender, adjustment of the awarding and project approach, and progressive tax refunds (instead of ex ante tax exemption). The latter enabled inclusion of additional sites long after the project was intended to have been completed. The project delay would have probably been longer had there not been an entirely efficient implementation structure. The evaluation feedback was clearly positive regarding the cooperation between the then DBSA Agency Management Services Unit of the implementing agency with the Department of Health, consultants and other participants.

The project was able to considerably improve the efficiency of HCT operations. Due to the availability of dedicated, designated rooms, it was easier to find HIV counsellors and people no longer had to wait for rooms to randomly become available. Also, the pride of being designated as a valuable employee by being given their "own" counselling rooms had a motivational effect on the counsellors. In this way, the HCT provision could be expanded per counsellor. Substantial "growing" material availability also contributed to this (for example, test kits, sterile gloves). People who test positive for HIV also receive good access to laboratory tests and ARV treatment.

Alternative solutions like containers, mobile HCT services or staff development provide an opportunity to evaluate the efficiency of the implemented construction measures by way of comparison. These types of alternatives would have specific benefits in terms of flexibility, reaching certain target groups and lower initial investments. However, they would also result in lower long-term cost efficiency and would be missing many of the effects of the clinic expansions (see "Effectiveness" section: aspects like trust placed in the clinics, the privacy of integrated rooms, motivation of employees).

Overall, the efficiency of the project is satisfactory.

Efficiency rating: 3

Impact

The overarching development objective (impact) of the project was to contribute to slowing the increasing HIV infection rate, and facilitating better care and treatment for those infected with HIV. There was and is no available indicator with data that makes it possible to draw direct conclusions about the success of the project with regard to the ultimate objective. This is due to the complex interdependencies between various factors and parallel projects which influence the HIV infection rates and treatment figures. Accordingly, no indicator was defined for the impact objective during project appraisal. However, in the context of evaluation, it remains useful to check whether the trends regarding treatment and infection rates are going in the right direction based on available indicators.

Initial national ARV treatment data were first collected starting in 2006 for expanding ARV care to clinics. The actual ARV treatment figures were compared to the statistically estimated number of people who should be treated ("people needing ARV treatment") for the annual UNAIDS national reports. This is a meaningful indicator that can show whether the treatment of those infected with HIV improved over the course of the project:

Indicator*	Trend during project implementation (objective: increase)					
Year	2006++	2007	2008	2009	2010	2011
Proportion treated with ARV out of people needing ARV treatment in South Africa	36%	42%	45%	56%	58%	75%

Data source: UNAIDS Country Progress Reports South Africa 2006, 2008, 2010, 2012

+ Defined by the evaluation mission

++ Initial available data

Even if the limited data quality forces conservative interpretation, the figures unmistakably point to a positive national trend in line with the ultimate objective: the proportion of those who were actually treated more than doubled during the term of the project.

The second aspect of the ultimate objective is the rate of new HIV infections (incidence). The development of the proportion of infected individuals (prevalence) between the ages of 15–24 is used as an internationally accepted approximation[5] for evaluating this trend.

Indicator*	Trend during project implementation (objective: slowing the increase)			
Proportion of HIV infections in the pop. of 15–24-year-olds	2002	2005	2008	2012
Eastern Cape	9.2%	11.7%	6.6%	6.2%
KwaZulu Natal	7.2%	16.1%	15.3%	12.0%
Mpumalanga	11.7%	10.1%	13.5%	10.0%

Data source: Republic of South Africa - South African National HIV Prevalence, Incidence, Behaviour and Communication Surveys, 2008 & 2012

* Defined by the evaluation mission

However, because prevalence rates only measure the total number of people infected with HIV in this age group, their informative value concerning the epidemic's development is limited. Numerous factors influence HIV prevalence rates: for example, they are no longer reduced if successful treatment of HIV-

[5] According to the "proxy indicator" accepted by UNAIDS

infected individuals prolongs their lives (proportion of those actually treated more than doubled during the term of the project; reduction of deaths due to AIDS). At the same time, the rate also increases due to early detection of the HIV virus due to an increase in the number of tests (also part of the project). Though data from the target provinces clearly shows not only that there was a slowdown in the increase during the course of the project, a trend reversal was also achieved: in all three target provinces, the figures point to a downturn in the rate of infection after dramatic increases. However, it should also be noted that KwaZulu Natal and Mpumalanga continue to be the hardest hit provinces in the nation.

Two significant types of contributions to slowing the infection rate can be expected from the HCT approach of this project: direct contributions due to behavioural changes and indirect contributions thanks to the biologically preventative effect of ARV treatment. The prerequisite for this in this case was the population's participation in the testing and counselling services. In this respect, despite the expansion of HCT in the target provinces as described, the effectiveness of the project for HIV prevention was limited due to the fact that very groups whose behaviour in particular contributes to high infection rates (men, high-risk groups) were inadequately reached by the project. As long as reliable HIV quick tests could not be performed everywhere by lay counsellors, receiving test results was a further critical obstacle. During the initial phase of the project, laboratory results were only available after two weeks. Many patients did not return to pick up their results. The distribution of quick tests parallel to the project (starting around 2007) made this much easier.

For those individuals tested negative, counselling and campaigns were intended to contribute to helping them stay negative. In reality, the influence of negative results on risky behaviour is low according to literature, despite the massive expansion of nation-wide communication campaigns mentioned above. Those with positive test results are more likely to change their behaviour according to available studies. However, the primary aspect critical for this group is successful acceptance into treatment. Linking HCT to follow-up measures was evaluated consistently as positive by the dialogue partners at the project sites: laboratory capacity and ARV availability were appropriate overall. However, quite a few individuals tested positive were lost because, after (quick) tests, it was often necessary to transfer patients from lay counsellors to a doctor or nurse and because a lab analysis was undertaken in each case before treatment began.

Despite existing challenges in the transition from HCT to HIV prevention, it should be noted that no one was treated with ARV without being tested first, and public clinics made up the majority of the HCT sites overall at the time of the project. In addition, as confirmed by other donors, linking patients to follow-up measures was much easier in HCT in clinics than when mobile HCT approaches were used, for example. In this respect, we can assume that the contribution of the project to expanding HCT in clinics – as described in "Effectiveness" – helped to create the prerequisites for massive expansion of ARV treatment. This treatment is not only life-saving for those affected. In the meantime, its expansion has also been recognised as an important HIV prevention approach due to reduced viral load and thus a lower risk of infection, especially where risky behaviour remains persistent.

Consequently, together with parallel consistent expansion of ARV availability, the project approach was suitable for achieving the impact objective and contributed significantly to a turnaround in the fight against HIV/AIDS in the target provinces.

The overarching development objective achieved met the expectations at project appraisal.

Impact rating: 2

Sustainability

The expansion of HCT, reduced number of new infections and the wider-spread distribution of ARV treatments over the course of the project also continued in the years after the project was completed according to the available data. As was the case for development during the project term, the continuing progress since then is also due to a number of reasons. The sectoral context demonstrated sustainable development in line with the project objectives, for example, through continual improvement of health policies, large-scale campaigns for HIV/AIDS prevention and requiring public clinics nation-wide to continue offering HCT. Sectoral development continues to offer a good foundation for long-term positive effects from the project.

The sustainability of the physical project measures depends on the construction quality to a major extent. This was tested in the technical ex post analysis of 43 project sites (see "Efficiency" section) and found to be acceptable at 90% of the sites. The type and extent of the quality defects identified at numerous sites was evaluated as acceptable in the given context. According to dialogue with clinic personnel then and now, technical shortcomings do not prevent appropriate utilisation of the HCT spaces that have been created. During evaluation, the identified maintenance was an improvement when compared to the technical analysis mission at several sites. Nevertheless, long repair times due to budget restrictions and bureaucratic reporting procedures are a daily nuisance for clinic personnel. The reorganisation in maintenance discussed by FC with the implementing agency during the final inspection of the project has not proceeded since then. At individual sites where the project included furnishing HCT rooms (with office furniture, for example), furnishings were only used specifically for HCT in the short term and — as expected — were then transferred into the general inventory of the clinic. At the same time, the HCT spaces created at other sites benefited from follow-up investments in items like air conditioning systems or in additional building extensions. The technical sustainability is thus satisfactory overall.

One key challenge in running HCT sustainably is reliable provision of trained personnel, especially lay counsellors, who are often paid using special funds or by NGOs instead of from a long-term, reliable clinic budget. Initiatives are currently in place to train HCT lay counsellors for wider fields of application and for taking on more responsibility so they can then be taken on as regular health personal (for example, as "assistant nurses"). Relevant training programmes have only begun on a pilot basis in KwaZulu Natal. However, they offer the opportunity to reinforce HCT personnel structures and integrated health care with sustained effect. As things stand at the moment, there are enough personnel available to continue using the spaces that have been created for high-quality HCT services.

Sustainability is rated as good overall.

Sustainability rating: 2

Erläuterungen zur Methodik der Erfolgsbewertung (Rating)

Zur Beurteilung des Vorhabens nach den Kriterien **Relevanz**, **Effektivität**, **Effizienz**, **übergeordnete entwicklungspolitische Wirkungen** als auch zur abschließenden **Gesamtbewertung** der entwicklungspolitischen Wirksamkeit wird eine sechsstufige Skala verwandt. Die Skalenwerte sind wie folgt belegt:

Stufe 1	sehr gutes, deutlich über den Erwartungen liegendes Ergebnis
Stufe 2	gutes, voll den Erwartungen entsprechendes Ergebnis, ohne wesentliche Mängel
Stufe 3	zufriedenstellendes Ergebnis; liegt unter den Erwartungen, aber es dominieren die positiven Ergebnisse
Stufe 4	nicht zufriedenstellendes Ergebnis; liegt deutlich unter den Erwartungen und es dominieren trotz erkennbarer positiver Ergebnisse die negativen Ergebnisse
Stufe 5	eindeutig unzureichendes Ergebnis: trotz einiger positiver Teilergebnisse dominieren die negativen Ergebnisse deutlich
Stufe 6	das Vorhaben ist nutzlos bzw. die Situation ist eher verschlechtert

Die Stufen 1–3 kennzeichnen eine positive bzw. erfolgreiche, die Stufen 4–6 eine nicht positive bzw. nicht erfolgreiche Bewertung.

Das Kriterium Nachhaltigkeit wird anhand der folgenden vierstufigen Skala bewertet:

Nachhaltigkeitsstufe 1 (sehr gute Nachhaltigkeit): Die (bisher positive) entwicklungspolitische Wirksamkeit des Vorhabens wird mit hoher Wahrscheinlichkeit unverändert fortbestehen oder sogar zunehmen.

Nachhaltigkeitsstufe 2 (gute Nachhaltigkeit): Die (bisher positive) entwicklungspolitische Wirksamkeit des Vorhabens wird mit hoher Wahrscheinlichkeit nur geringfügig zurückgehen, aber insgesamt deutlich positiv bleiben (Normalfall; „das was man erwarten kann“).

Nachhaltigkeitsstufe 3 (zufriedenstellende Nachhaltigkeit): Die (bisher positive) entwicklungspolitische Wirksamkeit des Vorhabens wird mit hoher Wahrscheinlichkeit deutlich zurückgehen, aber noch positiv bleiben. Diese Stufe ist auch zutreffend, wenn die Nachhaltigkeit eines Vorhabens bis zum Evaluierungszeitpunkt als nicht ausreichend eingeschätzt wird, sich aber mit hoher Wahrscheinlichkeit positiv entwickeln und das Vorhaben damit eine positive entwicklungspolitische Wirksamkeit erreichen wird.

Nachhaltigkeitsstufe 4 (nicht ausreichende Nachhaltigkeit): Die entwicklungspolitische Wirksamkeit des Vorhabens ist bis zum Evaluierungszeitpunkt nicht ausreichend und wird sich mit hoher Wahrscheinlichkeit auch nicht verbessern. Diese Stufe ist auch zutreffend, wenn die bisher positiv bewertete Nachhaltigkeit mit hoher Wahrscheinlichkeit gravierend zurückgehen und nicht mehr den Ansprüchen der Stufe 3 genügen wird.

Die **Gesamtbewertung** auf der sechsstufigen Skala wird aus einer projektspezifisch zu begründenden Gewichtung der fünf Einzelkriterien gebildet. Die Stufen 1–3 der Gesamtbewertung kennzeichnen ein „erfolgreiches“, die Stufen 4–6 ein „nicht erfolgreiches“ Vorhaben. Dabei ist zu berücksichtigen, dass ein Vorhaben i. d. R. nur dann als entwicklungspolitisch „erfolgreich“ eingestuft werden kann, wenn die Projektzielerreichung („Effektivität“) und die Wirkungen auf Oberzielebene („Übergeordnete entwicklungspolitische Wirkungen“) **als auch** die Nachhaltigkeit mindestens als „zufriedenstellend“ (Stufe 3) bewertet werden.