

KNOWING WHAT WORKS



Central Project Evaluation

ESTHER university and hospital partnerships in
Africa

PN 2016.2035.0

Evaluation Report

On behalf of GIZ by Klaus-Peter Jacoby (iSPO Institut für Sozialforschung, Praxisberatung
und Organisationsentwicklung GmbH)

Published version: September 2020

Publication details

Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH is a federal enterprise and supports the Federal German Government in achieving its objectives in the fields of international education and international cooperation for sustainable development.

GIZ's Evaluation Unit reports directly to the Management Board. It is separate from GIZ's operational business. This organisational structure strengthens its independence. The unit is mandated to generate evidence-based results and recommendations for decision-making, to provide plausible verification of results and to increase the transparency of findings.

The Evaluation Unit commissioned external independent evaluators to conduct this evaluation. This evaluation report was written by these external evaluators. All opinions and assessments expressed in the report are those of the authors.

Evaluator/s:

Klaus-Peter Jacoby, iSPO GmbH

Author/s of the evaluation report:

Klaus-Peter Jacoby, iSPO GmbH

Consulting firm:

Institut für Sozialforschung, Praxisberatung
und Organisationsentwicklung
Saargemünder Straße 40
66110 Saarbrücken
T: +49 681 985 01 67
E: ispo@ispo-institut.de
I: www.ispo-institut.de



Coordination and management

Claudia Kornahrens, Head of section
Jessica Schendzielorz, Evaluation manager
GIZ Corporate Unit Evaluation
Central project evaluations section

Responsible:

Albert Engel, Director
GIZ Corporate Unit Evaluation

Published by:

Deutsche Gesellschaft für
Internationale Zusammenarbeit (GIZ) GmbH

Registered offices:

Bonn and Eschborn

Friedrich-Ebert-Allee 36 + 40
53113 Bonn, Germany
T +49 228 4460-0
F +49 228 4460 - 1766

E evaluierung@giz.de

I www.giz.de/evaluierung

www.youtube.com/user/GIZonlineTV

www.facebook.com/gizprofile

https://twitter.com/giz_gmbh

Design/layout:

DITHO Design GmbH, Cologne

Printing and distribution:

GIZ, Bonn

Printed on 100 % recycled paper, certified to FSC standards.

Bonn, 09.2020

This publication can be downloaded as a pdf file from the GIZ-Website at www.giz.de/evaluierung. For a printed report, please contact evaluierung@giz.de

Contents

The Project at Glance	7
1 Evaluation Objectives and Questions	8
1.1 Objectives of the Evaluation.....	8
1.2 Evaluation Questions	8
2 Object of the Evaluation	9
2.1 Definition of the Evaluation Object	9
2.2 Results Model including Hypotheses.....	12
3 Evaluability and Evaluation Process	16
3.1 Evaluability: Data Availability and Quality	16
3.2 Evaluation Process	17
4 Assessment of the Project According to OECD/DAC Criteria	19
4.1 Long-term Results of Predecessor(s).....	Fehler! Textmarke nicht definiert.
4.2 Relevance.....	19
4.3 Effectiveness	25
4.4 Impact.....	37
4.5 Efficiency	40
4.6 Sustainability.....	44
4.7 Key Results and Overall Rating	47
5. Conclusions and Recommendations.....	48
5.1 Factors of Success or Failure.....	48
5.2 Conclusions and Recommendations	50
Annex.....	52

Separate Annex: Interview Coding List (with interview code only available to GIZ evaluation unit, password protected), and Evaluation matrix as Excel-file (in addition to annex within this document)

List of Figures and Tables

Figure 1: Results model.....	15
Table 1: List of partnership projects funded by the TC measure	11
Table 2: List of stakeholders of the evaluation and selected interviewees	18
Table 3: Goal attainment of funded project at output and project objective/outcome level	30

Abbreviations

ABS	Antibiotic stewardship
AMR	Antimicrobial resistance
BMBF	German Federal Ministry of Education and Research
BMG	German Federal Ministry for Health
BMZ	German Federal Ministry for Economic Cooperation and Development
CD	Capacity development
CPE	Central project evaluation
DAAD	German Academic Exchange Service
DAC	Development Assistance Committee (of the OECD)
Difäm	German Institute for Medical Mission e. V. (Deutsches Institut für Ärztliche Mission e.V.)
EA	European ESTHER Alliance
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
GloBe	GIZ Department for Sector and Global Programmes
HSS	Health system strengthening
IHP	Institutional health partnership
Int., Ints	Interviewee, interviewees
IPC	Infection prevention and control
MCH	Maternal, newborn and child health
NCDC	Nigeria Centre for Disease Prevention and Control
OECD	Organisation for economic co-operation and development
PAGEL	Partnerships for the Health Sector in Developing Countries
POCUS	Point-of-care ultrasound
QsiL	Quality assurance in line management
RKI	Robert Koch Institute
SDG	Sustainable Development Goal

SOP	Standard operating procedure
TC	Technical cooperation
WHO	World Health Organization
ZAS	Time recording (Zeitaufschriebe)



The project at a glance

Africa, regional: ESTHER university and hospital partnerships in Africa

Project number	2016.2035.0
Creditor Reporting System code(s)	12181 (70%), 12191 (30%)
Project objective	The conditions for patient safety in selected African countries within the framework of institutional health partnerships (IHP) are improved.
Project term	1 June 2016 to 30 November 2019
Project value	EUR 4,000,000
Commissioning party	German Federal Ministry for Economic Cooperation and Development (BMZ)
Lead executing agency	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
Implementing organisations (in the partner country)	The project funded selected health sector institutions in Germany and their African partners (e.g. university hospitals, public and private hospitals, research institutions, laboratories) based on standardised selection criteria for funding projects
Other development organisations involved	(-)
Target group(s)	The direct target groups of the partnership projects were the African health professionals involved in the partnership project interventions of the partnership projects (i.e. different hospital staff levels according to each project's focus). Indirect target groups were the patients of African health institutions involved in institutional health partnerships funded through the project. The specific partner groups varied according to the content of each project.

1 Evaluation objectives and questions

This chapter aims to describe the purpose of the evaluation, the standard evaluation criteria, and additional stakeholders' knowledge interests and evaluation questions.

The evaluation object was the ESTHER University and Hospital Partnerships in Africa Technical Cooperation (TC) project, carried out by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ). The project was funded by resources from the Health in Africa special programme and steered by the respective GIZ regional departments. It was not integrated into country programmes, though coordination with health sector projects is highly encouraged for any funded project.

1.1 Objectives of the evaluation

The Central Project Evaluations (CPEs) of projects commissioned by BMZ perform three basic functions: they support evidence-based decision-making, promote transparency and accountability, and foster organisational learning and contribute to knowledge management. The project has been selected as part of the random sample, i.e. the selection has not been driven by further specific situational evaluation objectives.

As the project ended in November 2019, the evaluation was carried out as a final evaluation, which implies a focus on verifying the effects of the technical cooperation and accountability. Further funding of institutional health partnerships (IHPs) is taking place through the University and Hospital Partnerships in Africa (PN 2018.2015.8) regional programme, which runs from January 2019 to December 2021 and is based on the same approach as the evaluated project, though with a different thematic focus. – the evaluated project: focused on patient safety, while the current project: focuses on e-health, i.e. health care practice supported by electronic processes and communication. However, due to the overlapping terms of the two projects, funding applications for the new project have already been selected and approved and can no longer take into account lessons drawn from this evaluation. In conclusion, the evaluation – though summarising relevant lessons learned for the ongoing project – primarily pursued a summative function and could be used for the strategy for a follow-on phase (Rahmenplanung 2021, currently being planned).

1.2 Evaluation questions

The project was assessed on the basis of standardised evaluation criteria and questions to ensure comparability by GIZ. These are based on the Organisation for Economic Co-operation and Development Assistance Committee ([OECD/DAC criteria](#)) for the evaluation of development cooperation and [evaluation criteria for German bilateral cooperation](#), relevance, efficiency, effectiveness, impact and sustainability. Aspects of coherence, complementarity and coordination criterion are included in the other criteria.

Specific assessment dimensions and analytical questions were derived from this framework. These predefined dimensions and questions form the basis for all central project evaluations in GIZ and can be found in the evaluation matrix (Annex 2). In addition, contributions to the 2030 Agenda for Sustainable Development and its principles (universality, integrative approach, leave no one behind (LNOB), multi-stakeholder partnerships) are taken into account, as are cross-cutting issues such as gender, the environment, conflict sensitivity and human rights. Aspects of the quality of implementation are also included in all OECD/DAC criteria.

Several more customised and/or additional questions are specified in the terms of reference of the evaluation. Apart from questions that duplicate the standard CPE questions, these include questions in regard to the BMZ commission concerning: (a) integration of the IHPs into the GIZ health portfolio (including synergy with other TC instruments such as integrated experts), (b) collaboration with a similar project (Hospital Partnerships initiative) of GIZ's Department for Sector and Global Programmes (GloBe) and the added value of the ESTHER project as a regional and thematically focused programme with a higher funding volume, (c) the benefits and costs of participating in the European ESTHER Alliance (EA), and (d) collaboration with relevant external actors such as the Federal Ministry for Education and Research (BMBF). Furthermore, questions were asked on methodological and administrative aspects, such as the pertinence of the funding modality (3-year competitive rounds) and the pertinence of the contractual modality for the funding projects. Finally, questions were included on (a) alignment of individual projects with the priorities of the health systems of the partner countries, (b) the effect of the funded projects on consolidation of the underlying institutional partnerships, and (c) the effect of the projects on the northern partner institutions. The additional questions were integrated into the common report structure for the CPEs (i.e. they are analysed under the relevant OECD/DAC criteria). Annex 2 gives a detailed overview of the additional questions specified in the terms of reference and where they are assessed in the report, indicating the respective chapters.

2 Object of the evaluation

This chapter aims to define the evaluation object, including the theory of change, and results hypotheses

2.1 Definition of the evaluation object

Framework conditions and core problem according to the project proposal

Sub-Saharan Africa is one of the poorest regions in the world. Among 37 countries categorised as countries with 'low human development' by the Human Development Index (HDI) 2018, 31 countries belong to this region. The Ebola outbreak in 2014 exposed the weakness of the health systems of most African states, which do not have the capacity of providing quality health services to their populations. While well-functioning essential services, particularly health services, can contribute to social stability, weak service provision may fuel the potential for social unrest.

Life expectancy at birth is as low as 57 years in West Africa and 64 years in East Africa, compared to a global average (according to 2018 estimates) of over 72 years (CIA 2019). Average health expenditure per capita in sub-Saharan Africa is USD 78.37 compared to a global average (according to 2016 estimates) of USD 1,026.40 (World Bank 2019). Worldwide, on average there are approximately 15 physicians available per 10,000 people, whereas in sub-Saharan Africa (according to 2015 estimates) there are only 2 (World Bank 2019). Weak service provision also leads to generalised distrust in service quality, thus negatively affecting health-seeking behaviour and the use of health services. Among other factors, the Ebola outbreak in 2014 was catalysed by the fact that a large proportion of the population avoided public health services and ignored instructions from the health workforce, thus delaying diagnosis and treatment and accelerating epidemic outbreaks.

In fact, health detriments due to inadequate treatment are widespread and contribute to the general distrust in public health services. Sound data on malpractices is not available, but lack of hygiene and poorly administered blood transfusions, injections and medicines are well-documented problems. It is estimated that approximately 1 in 10 hospital patients in developing countries acquires an infection during hospitalisation. Where data is available, hospital infection rates are as high as 18.9% in Mali and 14.8% in Tanzania (see GIZ 2016a). While patient safety is a minimum precondition for the effectiveness and increased use of health services, African states with weak health systems are not yet capable of ensuring a sufficient level of patient safety (the core problem according to the project proposal).

Some relevant causes for the core problem are: (a) lack of competence and capacity of health professionals, researchers and managers, (b) the weak safety culture of health-service providers in the region, (c) lack of evidence and knowledge on good practices for enhancement of patient safety, (d) weak knowledge management and peer learning culture with regard to both South–South and North–South cooperation, (e) lack of resources in general, and of linkages with potential funding partners and programmes in particular (see project proposal, GIZ 2016a).

TC measure: ESTHER university and hospital partnerships in Africa

Germany joined the ESTHER Alliance for Global Health Partnerships (EA) as early as 2004. Shortly thereafter, the ESTHER Germany Secretariat was established within GIZ. The Secretariat and the steering of several GIZ-funded health partnerships was hosted by the Programme to Foster Innovation, Learning and Evidence in HIV and Health Programmes of German Development Cooperation (PROFILE).

The specific object of this evaluation is the ESTHER University and Hospital Partnerships in Africa TC measure, referred to in the following as ‘the project’. The project was carried out by GIZ on behalf of BMZ. It had a **duration** of 3 years and 6 months from June 2016 to November 2019 and an overall **budget** of EUR 4,000,000. Though building upon previous experience with the funding of university and hospital partnerships and support to the Secretariat of the European ESTHER Alliance for Global Health Partnerships (EA), the TC measure was designed as a new project (i.e. it has no predecessor). It was originally designed as a stand-alone project until 2017, when BMZ launched the Hospital Partnerships – Partners Strengthen Health initiative. This included another TC measure with a similar partnership approach but different target institutions, funding modes and values, geographical focus, and selection criteria. Both projects were then coordinated under the common roof of the Hospital Partnerships initiative, even though both have maintained their strategic and operational independence.

The **objective** of the project was: The conditions for patient safety in selected African countries within the framework of institutional health partnerships (IHPs) are improved. The objective and its indicators were formulated before specific partnership projects were chosen. Therefore, the indicators do not specify changes in the partner countries but instead overarching result categories and the number of projects that contribute to them. These dimensions are (a) implementation of solutions for identified treatment errors, (b) implementation of training measures that address identified treatment errors, and (c) international dissemination of knowledge products developed by the funded partnership projects.

The project differed methodologically from GIZ’s usual TC measures due to the predominance of partnership project funding as the principal mode of delivery. Therefore, outcomes in the partner countries were not achieved through technical assistance directly provided by GIZ but through North–South or North–South–South partnership projects. The funding focused on already established partnerships between German and African universities and hospitals, with the German partners as funding recipients (i.e. applying for the funding and responsible for financial administration of the projects), and the partnerships operated independently, on the basis of financial resources provided by BMZ and administrated by GIZ. Complementary technical assistance

covered the selection process for funded partnership projects, methodological advice during the planning process, support to peer learning processes and networking with external stakeholders. Overall, the methodological approach consisted of the following outputs.

- **Output 1: Initiation and further support of institutional health partnerships.** Objective: The funded institutional health partnerships are working towards improving patient safety.
- **Output 2: Creation of mechanisms for continuous learning from institutional health partnerships.** Objective: Mechanisms for continuous learning from institutional health partnerships for the improvement of patient safety are created.
- **Output 3: Creation of linkages with stakeholders and supporting partners of institutional health partnerships.** Objective: Stakeholders and supporting partners of institutional health partnerships for the improvement of patient safety are better interlinked.

The direct **target groups** of the partnership projects were the African health professionals involved in the partnership project interventions (i.e. different hospital staff levels according to each project's focus). The final beneficiaries were the patients of health institutions in West African countries and other African countries that were supported through the Health in Africa special initiative or involved in already existing ESTHER partnerships. Overall, the project funded 15 partnerships involving 13 countries with a total of 603 million inhabitants (Cameroon, Côte d'Ivoire, Ethiopia, Ghana, Guinea, Kenya, Liberia, Malawi, Nigeria, Rwanda, Sierra Leone, Tanzania, Uganda). Due to the different profiles of the African health institutions with regard to direct delivery of health services or reference functions within the national health systems, the full extent of target groups that potentially benefited is not quantifiable. The **following partnership projects** were funded by the evaluated TC measure.

Table 1. List of partnership projects funded by the TC measure

Countries	Partner institutions	Title	Funding in EUR
Sierra Leone, Uganda	Charité, Institute of Tropical Medicine and International Health, Berlin Princess Christian Maternity Hospital (Sierra Leone) Virika Hospital, Fort Portal (Uganda)	Safe obstetric care in Sierra Leone in the light of outbreak preparedness and control	110,000
Rwanda	Charité Berlin, Institute of Tropical Medicine and International Health, Berlin University Teaching Hospital of Butare	Improving Patient Safety: prevention and control of health care-associated infections, antibiotic resistance, and highly contagious infections	110,000
Côte d'Ivoire, Guinea	Robert Koch Institute (RKI), Berlin Hôpital Régional de Faranah (Guinea) Centre Hospitalier Universitaire de Bouaké (Côte d'Ivoire)	Partnership to Improve Patient Safety and Quality of Care (PASQUALE)	169,890
Nigeria	Robert Koch Institute (RKI), Berlin Nigeria Centre for Disease Control, Abuja	Manual on Universal and Outbreak Infection Prevention and Control (MAURICE)	111,900
Tanzania	University Hospital Bonn Lindi Regional Referral Hospital, Sokoine Ligula Regional Referral Hospital, Mtwara	Improving patient safety in obstetric surgery	117,566
Ethiopia	University Hospital Düsseldorf Asella Teaching and Referral Hospital School of Health Sciences, Arsi University	Prevention and clinical management of nosocomial infections	109,800
Kenya	University Hospital Frankfurt am Main Kenyatta National Hospital, Nairobi	Strengthening systems for antimicrobial stewardship (ABS) and surveillance for health care-associated infections	110,000
Ethiopia / Tanzania	University Hospital, Ludwig-Maximilians-Universität (LMU) Munich	Improvement of diagnostics, treatment and management for patients through antibiotic	114,975

	Jimma University Medical Center (Ethiopia) Mbeya Zonal Referral Hospital (Tanzania)	resistance surveillance, ABS and diagnostic process optimisation	
Ghana, Côte d'Ivoire	University Medical Center Hamburg-Eppendorf Komfo Anokye Teaching Hospital, Kumasi (Ghana) Jean Lorougnon Guédé University (Université Jean Lorougnon Guédé) (Côte d'Ivoire)	Optimisation of microbiological diagnostics and therapy	209,508
Malawi	University Medical Center Hamburg-Eppendorf College of Medicine, Blantyre	Increasing patient safety through point-of-care ultrasound	109,940
Guinea	University Medicine Rostock Hôpital Régional de Kindia Laboratoire médical Guinéo-Allemand, Conakry	Increasing patient safety: organisational and infrastructural improvements and capacity development (focus on laboratory services)	110,000
Cameroun	Rostock University Medical Center Regional Hospital Limbe, Regional Hospital Bamenda	Increasing patient safety: organisational and infrastructural improvements and capacity development (focus on laboratory services)	110,000
Guinea	Heidelberg University Hospital Ignace Deen University Hospital, Conakry	Improving patient safety in emergency health care and hospital management	109,970
Liberia	German Institute for Medical Mission (Difam) Ganta United Methodist Hospital Phebe Hospital Saint Joseph's Catholic Hospital	Improved patient safety through development of knowledge management and competence-networks for infection prevention and antimicrobial resistances	110,000
Tanzania	University and Rehabilitation Clinics Ulm Kibaha Education Centre	Patient safety partnership: improving patient safety through e-learning and structured personnel development	110,000

2.2 Results model including hypotheses

Adjusted results model

In accordance with GIZ's quality assurance in line management (QsiL) requirements, the project elaborated a results model that covers all relevant results areas and results hypotheses, except for those related to integration into the BMZ Hospital Partnerships initiative, introduced at a later stage of the project term. Nevertheless, the results model was adjusted for the purposes of the evaluation, since it does not explicitly reflect some implications of the particular mode of delivery of the TC measure.

As described above (see Section 2.1), outcomes in the partner countries were pursued as a result of the partnership projects. These were funded through grant arrangements, a contractual arrangement which – unlike service-level agreements – did not involve GIZ in the management or steering of the funded interventions. The international health partnerships (IHPs) received technical advice during the planning stage and some accompanying support (e.g. for networking) and reported project progress to GIZ, but they were fully independent in implementing the funded measures. However, two additional outputs – related to horizontal learning among the IHPs and interlinking the IHPs with further stakeholders – were operated by GIZ and followed the usual TC results logic.

Therefore, two different **system boundaries** had to be built into the results model. The first layer considers the activities and outputs (outputs 1, 2 and 3) under the control of GIZ. The outcomes are related to the effects of technical assistance on the performance of the funded partnerships (as partly reflected in the project objective) and on the different levels of network strengthening pursued through the GIZ-controlled outputs. The second

layer considers the interventions of the partnership projects and related outcomes, which at some stages benefited from technical advice from GIZ but produced their intended outputs and outcomes independently. The adjusted results model is visualised in Figure 1; further description of intended changes will refer back to the numbering used in the visual model.

Output A basically covers the funding component of the project, including the initiation and criteria-based selection of partnership projects (**A-1**), based on existing quality standards of the European Esther Alliance (EA) and with a particular focus on already well-established, performing partnerships. Technical assistance under this output concentrated on supporting formulation of project strategies and advice on planning methodologies (e.g. formulation of logframes). During the planning stage, the project also coordinated with other GIZ bilateral and sector projects to optimise interlinkages and synergies among partnership projects (**A-2**). For the projects selected for funding, the TC measure offered initial training on patient safety and cooperation management-related topics, and further technical advice on aspects of capacity development (CD) in development cooperation settings. As already mentioned, the project had no further formal steering or management role in implementation of the partnership projects (**A-3**), in accordance with the contractual framework predefined by the commissioning party, i.e. by BMZ. The related project objective indicators therefore refer to implementation-related aspects as intermediate outcomes/level I outcomes rather than to actual partnership project outcomes. The results hypothesis is that the technical advice provided during the planning and selection stages ensured the engagement of the partners involved in the area of patient safety and that the partnerships therefore implemented specific solutions (**MI-1**) and further training measures (**MI-2**) that addressed identified deficiencies in patient treatment and care at the African partner institutions. As explained, the contractual framework did not entitle GIZ to hold the partnerships accountable for specific results, so that the outcomes envisaged for each partnership project were exclusively under the managerial control of the funding recipients. In general terms (considering the heterogeneity of the funded measures), the partnerships pursued intended outcomes at individual project level/outcome level II in regard to improvement of laboratory capacity and hygiene conditions at partner institutions (**O-1**), improvement of quality management (**O-2**) and improvement of the quality of patient treatment and care in selected clinical areas (**O-3**). Beyond the context-specific results of each partnership, one of the funded partnerships further developed and implemented an online course on patient safety, which will be accessible to all partnerships and to interested third parties, thus generating scale effects (**O-4**).

The objective of **Output B** is to create mechanisms for continuous learning from institutional health partnerships in the thematic area of patient safety. On the basis of experience and existing EA tools, the project fostered formative (self-)evaluation processes (**B-1**) oriented towards reflection on the effectiveness of the funded projects (versus mere output reporting), thus generating aggregated lessons learned beyond the context-specific experience of individual partnerships (**B-3**). The project further organised network activities in different formats to create spaces for continuous mutual exchange (**B-2**), thus ensuring that peer learning took place and fed back into the cooperation management of the funded partnerships (**B-4**). The underlying results hypothesis is that support for internal self-reflection and systematisation of results within each partnership and the dynamics of continuous peer learning processes would lay the groundwork for production of formal knowledge products (e.g. scientific papers, articles, presentations) by the institutions involved in the partnerships. The related project objective indicator measures the extent to which these products were then shared and disseminated among and beyond the partnerships (**MI-3**).

Output C supports broader external networking and aims to create linkages with external stakeholders and potential supporting partners for the funded projects in the field of patient safety. Through a secondment (a half-time staff position), the project supported the functioning of the EA Secretariat (**C-1**), with the aim of improving the strategic and operational planning, financial management and reporting of the ESTHER Alliance's activities, as well as organising stakeholder meetings and BMZ's participation in board meetings (**C-5**). Experience from the IHPs was documented for communication with development partners and other strategic stakeholders (e.g. research networks, private sector, **C-3**) and used for enhanced coordination (**C-4**) to better interlink the funded partnerships with other strategic actors in the health sector (**C-6**), thus improving synergies

between the effects of the TC measure and interventions by other development partners. At impact level, the networking support aimed to improve access to additional financing sources (**I-4**).

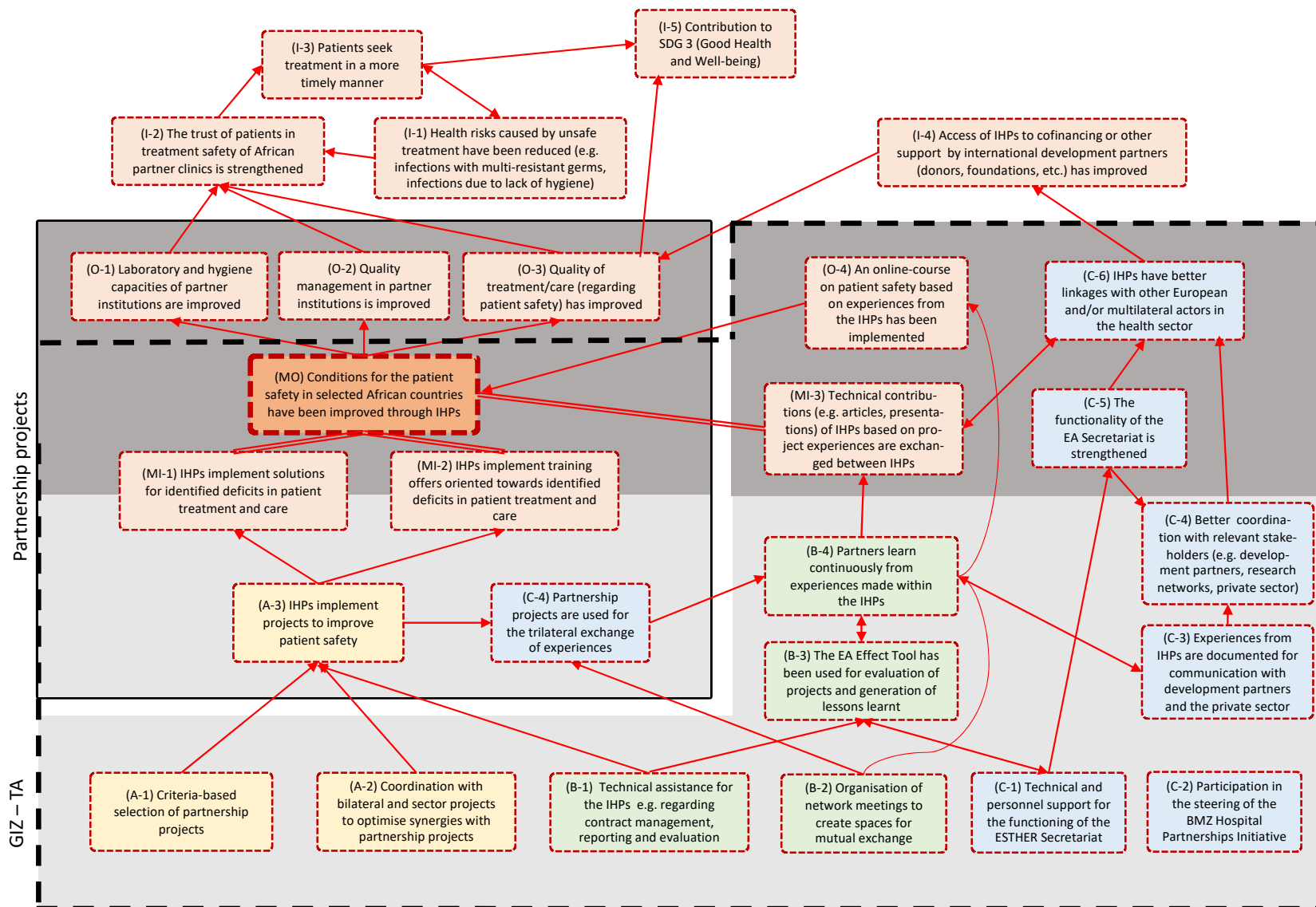
Beyond the mandate defined in the original project proposal (May 2016), the project also assumed a co-steering role in the secretariat of the BMZ Hospital Partnerships Initiative launched at the end of 2016 (together with Health Partnerships Global, the other funding programme for partnership projects in the health sector, managed by the GIZ Department for Sector and Global Programmes, GloBe) (**C-2**). This role included advisory functions on aspects of the BMZ initiative, such as cooperation management for partnership projects, identification of new focus areas, public relations, results-oriented monitoring and evaluation, and further strategic development of International Health Partnership support. Though the mandate for the advisory function for BMZ lay with the GloBe project, BMZ occasionally also requested advisory services from the ESTHER TC.

The evaluation considers the different **system boundaries** as explained above (i.e. both from the perspective of GIZ as provider of technical cooperation and from the perspective of implementers of the funded projects). Whereas the project objective indicators (referring to the operational performance of the project partners) were still within the system boundary of the technical cooperation provided by GIZ, the country-specific outcomes on patient safety had already exceeded this scope: They were **beyond** the influence of the project measures but **within** the system boundary of the funding projects (see Figure 1). Both modalities (technical cooperation and funding) converged again with regard to the aggregated impact. At that level, the TC measure aimed to reduce health risks resulting from unsafe treatment (e.g. infection due to lack of hygiene, infection with multi-resistant germs) (**I-1**), thus increasing patients' trust in the treatment safety of African partner hospitals (**I-2**). Increased trust would motivate patients to seek treatment in a timelier manner (**I-3**), thus – given better quality treatment and care (see **O-3**) – resulting in positive health outcomes as a contribution to Sustainable Development Goal 3 Good health and well-being (SDG 3) (**I-5**). Better access for the partnerships to further financing support by international development partners (**I-4**) – as addressed by the combined results of outputs 2 and 3 – would create better conditions for the continuation and further effective performance of the partnerships in the medium and long term.

Risks: The project was based on the assumption that health institutions involved in the international health partnerships (IHPs) were interested in the thematic area of patient safety. The main risk identified for the overall measure was the possibility that increasing economic pressure on universities, research institutes and hospitals in Germany could reduce the priority given to the thematic area and their engagement with partnership activities, thus compromising the funded partnership projects. This could, for example, materialise in partnership activities being delegated to postgraduate students or other less experienced personnel, which would be contrary to the principle of horizontal North–South cooperation on equal terms. Cultural barriers were identified as another potential risk (e.g. resulting in blame games in cases of low performance instead of mutual learning from mistakes).

Unintended results: During the inception mission, no reasons for unintended negative results could be identified. Since the diverse results of the 15 funded partnerships do not fully fit into the overarching results categories selected for the results model, not all positive results are covered by the results matrix of the programme. However, these results are intended.

Figure 1: Results model of the ESTHER University and hospital partnerships in Africa project (adjusted 12/2019)



3 Evaluability and evaluation process

Chapter 3 gives an overview of available basic documents for the evaluation (including an assessment of their currency and quality and their relevance for specific OECD/DAC criteria) and assesses the availability of monitoring data and the consequences for the evaluability of the TC measure.

3.1 Evaluability: data availability and quality

Availability of essential documents

Basic document	Is available (Yes/No)	Assessment of currency and quality	Relevant for OECD/DAC criterion:
Project proposal and overarching programme/funds proposal (etc.) and the additional information on implementation	Yes	Project proposal of May 2016 ('Additional information on implementation' not available)	Point of reference for all OECD/DAC criteria
Modification offers where appropriate	Yes	Modification offer (cost-neutral extension) as of 09/2018	(administrative content only)
Contextual analyses, political-economic analyses or capacity assessments to illuminate the social context	No	No country-specific analyses due to the regional focus of the programme	(-)
Peace and Conflict Assessment (PCA Matrix), gender analyses, environmental and climate assessments, Safeguards and Gender Management System assessments	No	Not available in the initial set of documents and not yet retrieved	(-)
Annual project progress reports and, if embedded, programme reporting	Yes	Annual progress reports 2017, 2018 and 2019	Effectiveness, impact, sustainability
Evaluation reports	No	No evaluation carried out before the CPE	(-)
BMZ country strategy National strategies	Yes	National health strategies and area specific strategies	Relevance
Sectoral/ technical documents (please specify)	Yes	Wide range of scientific articles about partnership projects	Points of reference for all OECD-DAC criteria
Results matrix	Yes	Limited scope due to the mode of delivery (see explanation in Chapter 2.2) but mostly complying with quality criteria	Effectiveness, impact, efficiency
Results model(s), possibly with comments if no longer up to date	Yes	Adequately reflects current intervention approach. However, a more detailed results model with modified system boundaries has been elaborated for the evaluation	Relevance, effectiveness, impact
Data from the results-based monitoring system (WoM) ¹	Yes	Monitoring system based on progress reports of the funded IHPs available for all projects,	Effectiveness, impact
Map of actors ¹	Yes	Available; includes prioritisation of stakeholders	(background for all criteria)
Capacity development (CD) strategy/overall strategy ¹	(-)	Funded partnerships are not subject to quality assurance in line management (QsiL) requirements	(-)

¹ Mandatory for all projects, based on Quality Assurance in line management (QsiL).

Steering structure ¹	No	(-)	(-)
Plan of operations ¹	Yes	Available for the entire duration of the project	Effectiveness, efficiency
Cost data (at least current cost-commitment report (Kostenträger-Obligo Bericht)). If available: cost data assigned to outputs	Yes	Efficiency tool completed	Efficiency
Excel spreadsheet assigning working-months of staff to outputs	Yes	see above	Efficiency
Documents regarding follow-on project (please specify if applicable)	(yes)	Ongoing TC on e-health (although not categorised as a follow-on measure.)	(Relevance, efficiency, effectiveness)

Baseline and monitoring data (including partner data)

Though indicators for the project objective complied with current quality criteria (see Section 4.3 for further details), their scope was necessarily limited. The methodological approach was based on funding projects that were selected after the approval of the measure, i.e. after formulation of the results matrix. Since the results matrix indicators were formulated before partnership projects were selected, they could only quantify targets for cross-cutting thematic categories instead of the actual effects of specific partnership projects. Since the indicators measured engagement in new topic areas (i.e. areas in which the partnerships had not been specifically working prior to the funded projects), the baseline was set at zero for all project objective indicators. Thus, measurement of the overall attainment of the project objective did not pose methodological challenges, but had to be complemented by an assessment of the individual goal attainment of each funded project.

For monitoring the partnership projects, the project supported the selected partnerships during the planning process, ensuring elaboration of project logframes that included outcome and output goals, and their respective indicators and activities. These logframes were the point of reference for half-yearly progress reports to GIZ. The progress reports covered: (a) results achieved in each intervention area (up to three per project), (b) assessment of goal achievement and reflections on the current state and/or reasons for deviations from initial planning, (c) summary of relevant knowledge on patient safety generated by the project, (d) updated information on partnership activities (part of and/or beyond the funded project), (e) effect/impact on the target group, country or region, and (f) need for action by GIZ and/or the partners themselves. The depth of the progress reports varies from substantiated to rather schematic assessments. The reporting requirements and quality assurance processes (through feedback cycles) were well-adapted to the characteristics of the partnership projects and reporting capacities of the institutions involved, though not comparable with the requirements of GIZ progress reports to BMZ (i.e. in regard to distinction of results levels, SMART criteria for indicators). Internal monitoring of GIZ-driven processes was based on operational plans that gave a detailed overview of how supporting activities beyond the partnership projects were operationalised and implemented.

3.2 Evaluation process

The evaluation mission consisted of an inception phase, carried out throughout November and December 2019, and an evaluation phase with interviews, carried out from mid-April to mid-May 2020. After a debriefing with the project team on 29 May 2020, the evaluation phase concluded with the submission of the draft evaluation report on 14 June 2020.

The evaluation phase coincided with the initial phase of the coronavirus pandemic, which significantly hampered implementation of the planned evaluation design. As a result of the inception phase, the design for the mission had planned for interviews (a) with all German universities involved in the partnership projects, (b) with at least one representative of an African partner-hospital per project, and (c) with representatives of bilateral or regional GIZ TC measures associated with the partnership projects.

Many of the German project partners were fully absorbed by the coronavirus response. Based on the results of previous partner consultations in the context of the ongoing TC measure for ESTHER partnership projects on e-health, implementation of the original design was considered neither feasible nor pertinent. Therefore, in coordination with the evaluation department of GIZ, the following decisions were taken: (a) instead of a complete survey of German partners, five partners/six projects were selected according to their anticipated current availability (i.e. the final sample does not follow conceptually or methodologically driven criteria); (b) as would have been the case for the initial design, African partners would be included in accordance with the advice of the German project partners, including consultation on the current feasibility or pertinence of interviews, implying that African partners would be contacted for the same six projects; (c) interviews with GIZ staff would be conducted as planned. Interviews, analysis of interview results and document analyses were based on guiding questions derived from the evaluation matrix (see also the assessment bases explained in Sections 4.2 to 4.6). Handwritten interview notes were digitally stored (using MyScript Nebo software).

As expected, responses to interview requests were slow at the beginning of the originally planned evaluation phase (20–30 April 2020), which was extended throughout the first half of May. Most German university partners were interviewed at a late stage, which meant that linkages to African partners could no longer be established, except for one partnership. Interviews with German partners were conducted for six projects. Responses from GIZ staff were more fluent and covered TC measures associated with 12 of the 15 projects. Interviews with other stakeholders (GIZ headquarters, BMZ, other institutional partners) had already been conducted during the inception mission and were thus not affected.

The evaluation was carried out as a remote evaluation by only one evaluator (Klaus-Peter Jacoby).

The following table shows a list of stakeholders and participants in the evaluation. It has been updated during preparation of the main phase (e.g. in regard to the number of participants, gender disaggregation).

Table 2. List of evaluation stakeholders and selected participants

Organisation/company/target group	Overall number of persons involved in evaluation (disaggregated by gender. m=male, f=female)	Interview participants (no. of persons, disaggregated by gender)	Focus group discussion (no. of persons, disaggregated by gender)	Workshop participants (no. of persons, disaggregated by gender)	Survey participants (no. of persons, disaggregated by gender)
Donors	4 (1m/3f)	4 (1m/3f)	-	-	
RM7					
ESTHER Alliance Switzerland					
German Academic Exchange Service (DAAD)					
German Federal Ministry of Education and Research (BMBF)					
GIZ headquarters	10 (5m/5f)	9 (5m/4f)	-	3 (0m/3f)	-
GIZ current and former project staff (same for funding rounds for patient safety and e-health projects)					
GIZ GloBe (including Health Partnerships Global project)					
GIZ Regional Department Africa					
GIZ Sectoral Department (FMB)					
GIZ Client Liaison and Business Development (AGE) – AG Förderprogramme					

External consultants on behalf of GIZ				
Partner organisations (direct target group)	7 (4m/3f)	7 (4m/3f)		
Representatives of the German health institutions involved in IHPs				
Representatives of the African health institutions involved in IHPs (one case only)				
GIZ Bilateral and regional TC portfolio	9 (3m/6f)	9 (3m/6f)		
GIZ representatives of bilateral health projects				

4 Assessment according to OECD/DAC criteria

4.1 Impact and sustainability of predecessor project

This section does not apply. The evaluated TC measure is not categorised as a follow-on measure.

4.2 Relevance

This section analyses and assesses the relevance of the project after introducing the methodology.

The assessment dimensions of the relevance criterion cover (a) the congruence of the project design with relevant strategic frameworks, (b) the extent to which the project design matches the needs of the target groups, (c) the pertinence of the project design to achieving the chosen project objective (results logic) and (d) the pertinence of strategic adaptations to changing framework conditions. The 'project concept', as defined in the underlying evaluation matrix, encompasses both project objective and theory of change (i.e. the results model) and the implementation strategy (e.g. methodological approach, results hypotheses).

Evaluation basis and methodology for assessing relevance

To evaluate the congruence with relevant strategic frameworks ([relevance dimension 1](#)), the project strategy was assessed in a document analysis of the extent to which the methodological approach was consistent with: (a) the strategic orientation of German development cooperation, namely BMZ's thematic strategy papers, policies and guidelines (BMZ 2019a, BMZ 2009a, BMZ 2019b, BMZ 2016a), (b) the general principles and quality criteria of the European ESTHER Alliance (EA 2015a) and its strategic framework for 2015–2020 (EA 2015b), (c) international standards and agreements, particularly of the World Health Organization (WHO), on the quality of patient care and safety (WHO 2002), the WHO approach to patient safety (e.g. as summarised in *Patient Safety: Making health care safer* (WHO 2017)), and the reference framework of the 2030 Agenda, i.e. the health-related SDG 3, and (d) the strategic priorities of the African partner countries' health sector policies and strategies. The analysis of the extent to which the project strategy addressed the core problems of the target groups ([relevance dimension 2](#)) implies analysis of (a) the extent to which the available evidence confirmed the core problem addressed by the TC measure, and (b) the extent to which the funded projects implemented solutions related to the core problem. Evaluating the pertinence of the project design ([relevance dimension 3](#)) referred to the extent to which the methodological approach actually addressed the causes of the core problem, as described in the project proposal (see GIZ 2016a), and analysed the quality of the project strategies) against

current GIZ quality criteria. In addition, the pertinence of any later adjustments to the methodological approach(es) was analysed (relevance dimension 4).

The **methodology** was similar for all four dimensions, mainly based on document analysis, but also including findings from stakeholder interviews. To evaluate congruence with strategic frameworks (assessment dimension 1), the project strategy was assessed using the approaches already mentioned; interviewees were representatives of relevant development cooperation or other funding agencies. For congruence with the needs of the target groups (assessment dimension 2) and the pertinence of the project design (assessment dimension 3), the analysis centred on the strategy of the TC measure and the context analyses of the funding project proposals (GIZ 2016b); it also considered the observations of the German project partners interviewed. For the reasons explained in Section 3.2, planned interviews with representatives of African partner-institutions could not be carried out. The data for analysing the pertinence of any adjustments to project strategies (assessment dimension 4) was drawn from the progress reporting of both the TC measure and the partnership projects; interviews with the GIZ staff involved and the selected German partner institutions were also considered.

Relevance dimension 1: the project design is in line with the relevant strategic reference frameworks

Germany joined the European ESTHER Alliance (EA), founded in 2002 by France, Italy, Luxembourg and Spain, in 2004, and has released operational funds since 2007 (ESTHER 2020a). Since then, hospital partnerships have received increasing attention as an instrument for health-system strengthening (HSS) and have been explicitly mandated in several **BMZ strategy and position papers**. The 2009 publication, *Sector Strategy: German Development Policy in the Health Sector* (BMZ 2009a), mentions hospital partnerships as a relevant tool for North–South knowledge transfer, at that time still focusing on HIV/AIDS control, in line with the initial thematic focus of the ESTHER Alliance (BMZ 2009a, p. 19). The current BMZ position paper on global health (BMZ 2019b) also highlights improvement of health services as a key topic, including hospital partnerships as a tool for strengthening health facilities in developing countries. In regard to the relevance of the regional focus, the project was initiated shortly before the 2017 launch of the BMZ Marshall Plan with Africa, which includes health as a priority sector and sets a specific target for realisation of hospital partnerships (BMZ 2017b, p. 32).

Based on the targets of the Marshall Plan with Africa and in cooperation with the Else Kröner-Fresenius-Stiftung (EKFS), BMZ created the Hospital Partnerships – Partners Strengthen Health initiative in 2016 (BMZ/EKFS 2017). The initiative comprised the ESTHER university and hospital partnerships and another TC measure on global health partnerships. The two TC measures differ in their funding value (from EUR 110,000 to EUR 200,000 for the ESTHER partnerships as opposed to EUR 50,000 for global health partnerships), their regional scope (Africa or global), the types of partnerships (focusing on reference institutions in the case of ESTHER), and their thematic scope (funding topic patient safety or thematic openness). Some interviewees felt that joint public relations under the roof of the BMZ initiative tended to dilute the conceptual particularities of both TC measures; in particular the contribution to overall quantitative targets, which are more pertinent for the smaller global health partnerships than for the ESTHER partnerships, with their set number of 15 (larger and more complex) funding projects with a 3-year-cycle (e.g. Ints 1, 2, 6, 13, 20, see also GIZ 2018b, p. 8).

In regard to **international standards and guidelines**, the conceptual and strategic foundations of the ESTHER Alliance set the key reference framework for the TC measure. The ESTHER Charter for Quality of Partnership (EA 2015a) defines several quality criteria, which could not be fully verified due to the lack of interviews with African partner institutions (e.g. ‘equity and respect’ between partners and the principle of ‘joint and equal responsibility’) but which were mostly present in the strategic design and identifiable in the documentation of the implementation process of the funded projects. For example:

- Partnerships were based on **formal agreements** and invested systematic efforts in ensuring the institutional commitment of the partner hospitals, including the provision of essential human resources and further contributions to fulfilling the projects (see GIZ-IHP 2019a to 2018o).
- Project proposals, reports and interviews with German partners indicated adherence to the principle of **reciprocity** through participatory design, management and review, though expertise exchange mainly focused on North–South knowledge transfer (Int 17, 18, 26, 27, 28).
- All partnerships focused strongly on building the **capability** of the African partner institutions, both at individual level (i.e. skills of health professionals) and at organisational level (e.g. standard operation procedures (SOPs), see Section 4.3 for details).
- The detailed documentation of implemented as opposed to planned activities and the financial reports complied with the principle of **transparency** (see GIZ-IHP 2018a to 2018o and 2019a to 2019o).
- According to the project reports, operational research activities and related data collection were subject to **ethical clearance** processes.

Furthermore, the *Strategic Framework of the EE A 2015–2020* (EA 2015b) defines relevant implementing partner institutions, capacity focus areas and intervention areas. Targeted partner institutions include hospitals, universities and research institutions, thus coinciding with the key partners targeted by the TC measure. The same applies for targeted capacity development CD areas, such as service delivery, professional development and operational research, which are all mandated by the strategic framework. The funding topic, patient safety, is one of the mandated intervention areas, alongside specific clinical areas that coincide with clinical intervention areas of the funded projects (e.g. maternal, newborn and child health (MCH), surgery, quality improvement).

Conceptually, the TC measure builds on the WHO approach in *Twinning Partnerships for Improvement* (WHO 2016b), which defines principles for the planning and management cycle of partnership projects, and which gives orientation for the technical support provided by GIZ. The funding topic considered WHO priorities that define patient safety as a 'fundamental principle of health care', stating that 'delivering safer care in complex, pressurised and fast-moving environments is one of the greatest challenges facing health care today' (WHO 2017, p. 1)

Finally, the TC measure and the funded projects contributed to the 2030 Agenda, in particular to achieving the health-related SDG 3 (Good Health and Well-being), with contributions to specific targets depending on the areas of intervention of individual projects (e.g. patient safety in obstetric care, contributing to SDG 3.1 and 3.2 for maternal, newborn and child health (MCH); infection prevention, contributing to SDG 3.3 for elimination of infectious diseases). The partnership approach itself further contributed to SDG 17 (Partnerships for the Goals), particularly SDG 17.6 for knowledge sharing, and 17.9 for capacity building.

In regard to their alignment with national strategic reference frameworks, project plans were predominantly designed according to the needs and requests of the African partner-institutions (see relevance dimension 2) but also connected implicitly or explicitly with national sector strategies – either specific patient safety-related strategies (e.g. strategies to combat antimicrobial resistance (AMR) in Tanzania, Kenya and Ghana) and sector strategy targets (e.g. reduction of nosocomial infections in Rwanda, outbreak control in Nigeria), or to general service improvement targets, to which patient safety interventions contributed (e.g. improvement of MCH in Liberia and Tanzania, improving availability and use of medical equipment in Malawi).

As a whole, the project was consistently aligned with the relevant strategic reference frameworks at all levels (German development cooperation, international standards and guidelines, sector strategies of partner countries), considering the challenge of discerning the respective approaches and strategic orientation of the two BMZ-funded TC measures at communicational level.

Relevance dimension 1 – the project design is in line with the relevant strategic reference frameworks – is rated at **28 of 30 points**).

Relevance dimension 2: the project design matches the needs and problems of the target groups

In regard to the **problems and needs of patients**, according to WHO estimates (see World Health Organization 2019c, p. 2f) as many as 1 in 10 patients is harmed while receiving hospital care. The harm is caused by a wide range of adverse events (e.g. delayed diagnoses, treatment errors, unsafe medication, nosocomial infections), with nearly 50% of these considered preventable. The occurrence of adverse events due to unsafe care is likely to be 1 of the 10 leading causes of death and disability across the world. Recent evidence shows that 134 million adverse events occur each year in low-income and middle-income countries, resulting in 2.6 million deaths (see NASEM 2018). For multiple reasons (e.g. resource constraints, deficient infrastructure and supply, workforce availability, capability and sensitisation), challenges for patient safety in the African region are even more severe. The probability of acquiring a health care-associated infection is up to 20 times higher than the worldwide average (WHO 2020a). Thus, the funding topic is pertinent to reduction of severe, including life-threatening, risks for patients. Interviewees unanimously confirmed the (extremely) high relevance of the funding topic and its immediate relevance for the final beneficiaries. Many interviewees also highlighted the relevance of several funding projects for mitigation of the current coronavirus pandemic, in particular referring to projects that engaged in areas related to infection prevention and control (IPC) (Ints 17 to 20, Ints 26 to 28).

Rather than a set of specific interventions, patient safety is a fundamental principle of health care that applies in different ways to different health service areas, including clinical, organisational and governance aspects. Thus, the funding topic of the TC measure was sufficiently broad, to allow university and hospital partnerships to identify specific measures that responded to the needs of the African partner hospitals and corresponded with the expertise of the German partners. Defining a broad, overarching funding topic that was both intrinsically relevant and sufficiently flexible in its areas of intervention, was considered a key strength of the TC measure by many interviewees (including Ints 1, 2, 6, 8, 12, 14, 17, 18, 20).

Project reports and interviews stated that the **needs of the African partner institutions** were adequately considered by various mechanisms, according to the previous history and general context of their respective partnership relations prior to or during the design phase:

- Partnerships with a long history of collaboration were in a position to collaboratively build the project design based on field knowledge and experience from prior activities (e.g. Ints 18, 28).
- German partner institutions of other, newly established, partnerships could, nevertheless, count on coordinators with a personal history in the local context and thus, field knowledge and/or personal ties to the African partners (e.g. Int. 17).
- In one case, a representative of the German partner institution was working temporarily as a CIM expert in the local setting prior to the funding project, so that the project design could be formulated in the country and in direct exchange with the African partner.
- All interviewees from German partner institutions reported intense discussions with the African project partners on identification and operationalisation of intervention areas.
- According to the project plans and project reporting, most projects considered taking further diagnostic steps and situational analysis at an early stage of the implementation process to inform the design of training, clinical guidelines and other capacity-development measures.

Since interviews with representatives of the African partner institutions were lacking, the positive findings could not be validated from their perspective, except in a single case. Most of the project reports, however, highlighted the involvement and motivation of the African partner workforce, which to a certain degree indicates the relevance of project content for their working environment. Though some projects also reported difficulties in maintaining communication flows with leadership levels of the African partner institutions, these were mostly attributed to political and organisational factors and/or external factors (such as unrest or strikes). In one case, issues due to the presence in the general background of another development partner, seemingly prioritised by the African partner institutions, were reported (see project reports GIZ-IHP 2018a-o and 2019a-o).

In regard to the **inclusion of gender aspects**, most partnerships reported efforts to maintain gender-balanced participation in capacity-building measures. Participation in related training and events was usually disaggregated by gender. However, other dimensions of gender mainstreaming beyond gender-balanced participation (mostly understood as balanced according to the proportion of women and men in the overall workforce) were not mentioned in either the project designs or reporting. Only two partnerships explicitly reflected on additional gender aspects, considering gender roles and stereotypes, including possible interventions with male colleagues. However, these considerations referred to lessons learned and prospects for future interventions rather than to the funding projects of the evaluated TC measure. Overall, 4 of the 15 funding projects either did not report on gender-balanced participation or reported that they could not influence the gender balance since such decisions were taken by the African partner only (GIZ 2019a to 2019o).

Project applications and reporting did not explicitly refer to the **leave no one behind (LNOB)** principle, since exclusion patterns cannot be significantly addressed by focused clinical interventions. However, since most partnerships involved public hospitals (with one exception only) it is plausible that the projects did not enhance privileged access to improved health services.

In summary, the core problem and the funding topic were highly relevant, and the interventions of the funding projects corresponded to the problems and needs of the African partners. Gender-mainstreaming aspects were limited to gender-balanced participation, without reflecting gender-transformative aspects. Relevance dimension 2 – the project design matches the needs and problems of the target groups – is rated at **27 of 30 points**.

Relevance dimension 3: the project is adequately designed to achieve the chosen project objective

The results hypotheses (see Section 2.2) are generally plausible. Due to the nature of the project as a funding programme, the project objective indicators could only define generic cross-cutting thematic categories that could not capture the actual results achieved by the partnerships but only the extent to which the funded partnerships implemented solutions in line with the funding topic. Achievement of these indicators was ensured by the consistent application of the assessment criteria for selection of the funding projects and technical support for the involved partners during the planning and implementation phase, including involvement of GIZ staff in progress monitoring (e.g. setting the criteria for the project reports and occasional, selected project visits). However, achievement of the objectives of the funding projects was beyond the system boundary for GIZ and was the responsibility of the funded partnerships.

Although methodologically streamlined in accordance with formats set by GIZ, the goal-system levels (outputs, project or outcome objectives) were interpreted in different ways in the project proposals. Output-level results were frequently formulated as concluded activities, and project objectives often did not extend beyond an aggregated output level (or if they did, reporting did not necessarily reflect the intended outcome-level results). However, some partnerships defined objectives and indicators that even exceeded the outcome level, instead defining results between outcome and impact level (e.g. facility-based mortality rates). Most of these inconsistencies, however, can be attributed to the fact that project partners did not routinely apply logframe planning methodologies, so that some formal inaccuracies were to be expected without compromising the technical soundness and quality of the interventions from a clinical perspective. Considering the background of the partners (i.e. partners beyond the usual development cooperation landscape, funded especially to bring in another kind of expertise) and the scale of the projects (with a typical funding value of approx. EUR 110,000), the quality of the project designs was convincing. Furthermore, the focus of the TC measure on African reference institutions resulted in plausible hypotheses in regard to channels for spill-over effects in other segments or levels of the partner countries' health systems. Although no indicators and objectives were formulated at this level, some reflections on health-system strengthening (HSS) beyond the limits of the bilateral (or in some cases tri-lateral) partnerships were present in most project proposals. This aspect constituted an important peculiarity of the evaluated TC measure, considering the frequent limitation of results to the immediate sphere of bilateral partnerships, as identified by studies and evaluations of other partnership programmes (e.g. GOPA 2020).

All in all, the generic formulation of the indicators of the project objective was pertinent for the type of programme and adequately complemented by the project assessment criteria and GIZ technical support for the partnerships. Despite some methodological shortcomings in the application of usual TC planning mechanisms, the funded partnerships were also clearly focused on clinical changes, sustained by plausible intervention packages. Furthermore, channels for contributions to other segments or layers of the health systems were at least reflected upon).

Relevance dimension 3 – the project is adequately designed to achieve the chosen project objective – is rated at **17 of 20 points**.

Relevance dimension 4: the project design was adapted to changes in line with requirements and re-adapted where applicable

In regard to the steering and technical support role of GIZ, the most important change in the overall project setting was the integration of the two GIZ hospital partnership funding TC measures under the roof of the BMZ Hospital Partnerships – Partners Strengthen Health initiative. The integration took place in the third quarter of 2017, shortly after the beginning of the implementation term of the evaluated TC measure. The project participated in joint steering mechanisms (e.g. strategic committee, secretariat, monthly joint meetings) and public relations. It also took on several advisory functions for the initiative, including in cooperation with the EA, cooperation with the private sector, identification of e-health funding opportunities, and for monitoring of funding projects and further development of the Hospital Partnerships initiative. These additional tasks absorbed approximately 50% of a job position. This was not calculated in the original instrument design and had to be covered by gradually reducing inputs to output B (learning mechanisms) and output C (networking) (see GIZ 2018b).

Although several interviewees highlighted the need for coordination and clarification of the particular design characteristics of the two hospital partnership TC measures and their areas of intersection (Ints 10, 12, 15, 16), the pertinence of the common steering mechanisms was repeatedly questioned (e.g. Ints 1, 2, 6, 10, 12, 14), both in regard to cost-effectiveness (as a relation between the personnel input and the added value for operational activities) and to dilution – rather than clarification – of the particularities of each funding mechanism, for example by providing funding to the same partnerships in Africa or by progressively diluting the focus on mobilisation of German voluntary health staff in the global initiative. Despite BMZ's preference for maintaining both TC measures under one roof, the joint steering mechanism was finally suspended. To a certain extent, reasons for the failure to establish meaningful joint steering mechanisms stemmed from the planning history, since both projects emerged from different funds, were planned and implemented by different areas of GIZ and (due to the sequence of project as opposed to BMZ-initiative planning) did not take the overarching steering inputs into consideration in their original project proposals – either financially or conceptually.

At the level of the partnerships, risks and assumptions – particularly in regard to acceptance of patient safety topics and the resource-related limitations of German and African partners – were formulated realistically for the overall project. Most individual funding projects were implemented in line with their operational planning. Only a few partnerships were forced to adjust or abolish single outputs due to context changes or changed priorities of the African partners in the time span between project design and the start of implementation. In all such cases, the overall orientation of the funding project was not altered by the adjustments.

To sum up, the funding round for patient safety was carried out as planned. The establishment of a joint steering mechanism with the BMZ initiative did not generate the expected added value for the coordination and complementarity of the two integrated hospital-partnership TC measures. At the level of the funding projects – weighted higher as the core contribution to the project objective – only a few strategic changes were necessary and were implemented in line with the objectives pursued. Relevance dimension 4 – the project design was adapted to changes in line with requirements and re-adapted where applicable – is rated at **15 of 20 points**.

Criterion	Assessment dimension	Score and rating
Relevance	The project design is in line with the relevant strategic reference frameworks.	28 of 30 points
	The project design matches the needs of the target group(s).	27 of 30 points
	The project concept is adequately designed to achieve the chosen project objective.	17 of 20 points
	The project design was adapted to changes in line with requirements and re-adapted where applicable.	15 of 20 points
Overall Score and Rating		Score: 87 of 100 points Rating: Successful

4.3 Effectiveness

The effectiveness assessment takes into account (a) attainment of the project objective indicators, (b) the extent to which the project's activities and outputs contributed substantially to the observed outcome, and (c) the occurrence of positive or negative unintended results at output or outcome level.

Methodology for assessing effectiveness

First, effectiveness was assessed against the objective and the relevant indicators (effectiveness dimension 1 according to the evaluation matrix, Annex 3). In general, the project objective indicators complied with SMART criteria but – due to the nature of the project as a funding programme – could only define generic cross-cutting thematic categories that could not capture the actual results achieved by the individual partnerships.

<i>Project objective indicator according to the proposal/ original indicator</i>	<i>Assessment according to SMART criteria/assessment</i>	<i>Adapted project objective indicator</i>
Indicator M1: The proportion of partnerships between African and German health institutions funded by the project that implement a gender-sensitive solution for an identified patient treatment deficiency has risen from 0% to 80% Base value: 0% Target value: 80% Source: Assessment of the project reports of the funded partnerships	Specific: partly (limited to a generic results variable that could not take into consideration the actual scope of the individual funding projects) Measurable: yes Achievable: yes Relevant: yes Time-bound: yes Note: the baseline zero related only to the project-specific funding context and does not consider previous partnership activities	The indicator was assessed as proposed in the results matrix, complemented by qualitative analysis of actual results achieved by each partnership. Furthermore, the analysis took into account if interventions related to patient safety built on previous activities in this area, or if partnerships were entering the thematic area for the first time as a result of the funding.
Indicator M2: The proportion of partnerships between African and German health institutions funded by the project that implemented specific training measures based on identified and analysed treatment deficiencies has risen from 0% to 80% Base value: 0%	Specific: partly (limited to a generic results variable that could not take into consideration the actual scope of the individual funding projects) Measurable: yes Achievable: yes Relevant: yes Time-bound: yes Note: the baseline zero related to the project-	The indicator was assessed as proposed in the results matrix but complemented by qualitative analysis of the scope, utilisation and (to the extent possible) results of implemented training measures.

Target value: 80% Source: Assessment of the project reports, training protocols	specific context and did not consider previous training activities of each partnership.	
Indicator M3: The number of technical and scientific articles produced by the funded partnerships and related to patient safety that have been discussed in international networks has risen from 0 to 10. Base value: 0 Target value: 10 Source: Assessment of network meeting protocols and materials presented (posters, presentations, publications)	Specific: mostly (leaving room for interpretation of the types of products and the types of international networks that qualify for the indicator) Measurable: yes Achievable: yes Relevant: yes Time-bound: yes Note: the baseline zero related only to the project-specific funding context and did not take into account previous publications.	The indicator was assessed as proposed in the results matrix.

A contribution analysis was used to evaluate how activities and outputs of the TC measure contributed to achievement of outcomes M1–3 (effectiveness dimension 2). The analysis followed the principles formulated by the commissioning party (see GIZ 2015) by (a) documenting intended outcomes, related project interventions and potential external factors, (b) analysis on the basis of the project theory of change, (c) gathering evidence for results achieved and the contribution of project interventions as opposed to other factors, and (d) formulating a ‘contribution history’. Due to the nature of the project (a high number of individual projects instead of one project with a more complex set of interrelated interventions) further reiterative analyses were not feasible.

The hypotheses for the contribution analysis at outcome level are:

- **Hypothesis 1:** The combination of financial grants and planning assistance provision (A-1) has led to implementation of solutions for identified deficiencies in patient treatment and care (MI-1) and the related implementation of training measures (MI-2).

For the outcome level of the funded projects:

- **Hypothesis 2:** Implemented solutions (MI-1) and capacity development measures (MI-2) implemented by the partnerships (see the individual project plans) have improved the conditions for patient safety in the target facilities (in regard to laboratory and hygiene capacities (O-1), quality management (O-2), quality of treatment and care (O-3), or other outcome categories as specified in the project plans).
- **Hypothesis 3:** Exchange of experience (B-4) and technical contributions (MI-3) combined with TC support for the coordination with relevant stakeholders, such as development partners, the private sector (C-4), have contributed to better linkages of IHPs with other European and/or multilateral actors in the health sector (C-6).

In regard to the occurrence of unintended results (effectiveness dimension 3), three different categories must be distinguished: (a) anticipation of unintended results (i.e. the extent to which the project has anticipated and adequately managed risks), (b) unanticipated negative results, and (c) unintended positive results.

In regard to attainment of project objective indicators (effectiveness dimension 1), **the methodology** was based on document analysis (progress reports). Analysis of the actual results achieved by each partnership was based on assessment of the individual project indicators and reports, according to each partnership's intended goals. Furthermore, interviews with selected representatives of German partner organisations were carried out. The contribution analysis (effectiveness dimension 2) was based on the same methods. Whereas goal attainment was well documented, the scope of the contribution analysis was seriously hampered by the lack of access to the African project partners (see Section 3.2), since a consistent contribution history would rely on capturing knowledge, perceptions and judgments from the different perspectives of the stakeholders involved. Unintended results (effectiveness dimension 3) were mostly addressed by open questions to all interviewees.

Effectiveness dimension 1: the project achieved the objective (outcome) in accordance with the project objective indicators

Assessment of indicator M1: the proportion of partnerships between African and German health institutions funded by the project that implemented a gender-sensitive solution for an identified patient treatment deficiency has risen from 0% to 80%

For the understanding of project objective indicators 1 and 2 it is essential to recall the system boundaries as indicated in the results model (see Figure 1). Due to the grant contract mode, specific outputs were implemented under the full responsibility of the funded partnerships and therefore beyond the direct operational influence of GIZ. The partnership projects implemented solutions for:

- hygiene improvement for prevention of nosocomial infections (eight cases),
 - management of antimicrobial resistance (AMR) and antibiotic stewardship (ABS) (six cases),
 - allocation of patients according to treatment priority (three cases),
 - patient safety in laboratory services (beyond the two areas mentioned above) (two cases),
 - prevention of infectious diseases in epidemic outbreak situations (two cases),
 - improvement of patient safety in obstetric care (surgery, emergency care) (two cases),
 - clinical waste management (two cases),
 - fostering a general focus on patient safety in emergency health care (one case) and
 - improving patient access to diagnostic services through mobile technology (one case).
- (The total number of cases here exceeds the number of projects due to individual projects implementing more than one solution.)

At operational level, the approaches covered a wide range of contributions, including training and mentoring (see indicator M2), formulation of clinical guidelines/protocols and standard operating procedures (SOPs), introduction of new or adjusted management processes, instruments and structures, minor infrastructural adjustments and provisions for better use of existing infrastructure, local production of consumables, provision of equipment and consumables, simulation exercises and improvement of laboratory services.

For the gender dimension of the indicator, the findings summarised in Section 4.2 apply. The only gender aspect reported was the effort to support gender-balanced participation in project interventions. Of the 13 partnerships which reported gender-disaggregated numbers of participants, 11 reported a gender balance, at least in regard to the proportion of women and men in the overall workforce. Two projects reported the inclusion of mostly female target groups, which tend to be neglected by clinical change projects (sensitisation on hygiene for cleaning staff). However this inclusion originated from functional considerations rather than from a gender perspective. No interventions that would take into consideration male or female roles, stereotypes or gender-specific needs have been reported. Experience showed that clinical experts lacked sufficient understanding of gender-transforming mechanisms and could not plan and implement them without specific support (and about which – according to project staff – they were often reluctant, since they perceived that gender-transformative activities were outside the scope of the project).

Overall, indicator M1 was **fully achieved in a quantitative sense (for the patient safety dimension)**, with the gender sensitivity dimension only reflecting a very basic understanding of the issue.

Assessment of indicator M2: the proportion of partnerships between African and German health institutions funded by the project that implement specific training based on identified and analysed treatment deficiencies has risen from 0% to 80%.

All 15 partnerships implemented training measures. Thematically, the training provided was related to the deficiencies and measures mentioned under indicator 1. As well as training related to the specific clinical focus of

each partnership, further training on managerial and other complementary skills was carried out by several partnerships (e.g. on quality management, leadership, clinical research), but always from an instrumental perspective, i.e. contributing to their respective clinical objectives. Training formats included both theoretical and practical, hands-on training for clinical staff, blended-learning modalities, online courses, self-learning platforms, coaching and mentoring. Project reports and interviews provided numerous examples of evidence-based elaboration of training content (e.g. situational analyses, baseline studies).

Since numbers of participants were not uniformly reported, the overall reach of training measures could not be exactly determined. Though quantities were available for 13 of 15 partnerships, participant numbers were frequently reported per training event, thus failing to capture the actual number of health professionals who benefited. Based on the total number of participants per event, the overall reach of all training measures implemented exceeded 2,000 participants. Even though the number of beneficiaries (who in many cases participated in multiple events) was presumably much lower, the quantitative reach of the skills development measures is undoubtedly significant. Approximately half of the partnerships reported on the application of knowledge, though only in a few cases sustained by evidence. Overall, the indicator was **fully achieved**.

Assessment of indicator M3: the number of technical/scientific articles related to patient safety produced by funded partnerships that were discussed in international networks has risen from 0 to 10.

Operational research activities on clinical topics related to the project objectives were an integral part of the university and hospital partnerships and were reported for 12 of the 15 funding projects. At the time of the evaluation, four partnerships (Difäm/Liberia, Charité Berlin/Rwanda, RKI/Guinea, RKI/Nigeria) had published a total of eight articles, with a further three articles in the process of publication; most were co-authored by members of the German and African partner institutions. Further publications, two doctoral theses (both from the Heidelberg/Guinea partnership) and one master's thesis (from the Hamburg/Ghana partnership) are envisaged. Most of the articles deal with clinical research (e.g. on AMR, clinical diagnostics in emergency care, complications in obstetric surgery), while others deal with methodological topics (such as e-health solutions, participatory IPC approaches). In addition to the articles mentioned above, 33 (mostly oral or poster) presentations on research results and/or project experience had been given at international conferences or network meetings by the end of the TC measure in November 2019, including at:

- European Congress of Clinical Microbiology and Infectious Diseases (ECCMID), Amsterdam 2019
- Congress for Infectious Diseases and Tropical Medicine, Cologne, 2019
- Conference of the German Society for Tropical Medicine and Global Health, Munich, 2019
- Congress on Tropical Medicine and International Health, Liverpool, 2019
- Humanitarian Congress, Berlin, 2019
- International Congress on Pathogens at the Human-Animal Interface (ICOPHAI), Quebec, 2019
- Grand Challenges Meeting of the Bill & Melinda Gates Foundation, Berlin, 2018
- Meetings of the regional AMR network (see assessment dimension 2)
- College of Medicine Research Dissemination Conference, Blantyre, Malawi, 2019

The number increased slightly between the last progress report and the time of the evaluation. Since research products were not consistently listed in the final reports of the funding projects, the exact number could not be verified. It is clear, however, that **indicator 3 has been overachieved**.

Additional criterion – goal attainment and outcome-level results of funding projects

The following table gives an overview of the goal-attainment and outcome-level results of the funding projects, showing (a) the project objectives, (b) the results at output level, (c) the attainment of the project goals and outcome-level results within the partner hospitals and (d) the available data sources for the 15 funding projects.

Table 3: Goal attainment of funded projects at output and project objective/outcome level

Project partners and objective	Results at output level	Project goal-attainment and outcome-level results	Sources
Charité Berlin/Sierra Leone and Uganda: Safe obstetric care in Sierra Leone in the light of outbreak preparedness and infection control	Outputs achieved (1) Training in IPC, emergency care and Ebola response, including a midwifery training module of the National School of Midwifery. (2) Improved equipment (2 sterilisers), including provisions for operation and maintenance. (3) Operational research projects on facility-based deliveries and obstetric complications.	Project objective achieved Increased staff skills and clinical improvements in IPC and obstetric emergency care. Quantitative evidence on improved facility-based maternal mortality and increased number of facility-based deliveries.	Project reports Interviews (German partner, GIZ)
Charité Berlin/Rwanda: Improving patient safety: prevention and control of health-care-associated infections, antibiotic resistance and highly contagious infections	Outputs achieved (1) Local procurement and distribution of materials for infection prevention (disinfectants, dispensers). (2) Training and simulation exercises on the human-animal interface, AMR containment and outbreak preparedness. (3) SOPs for detection of AMR established. (4) Operational research on the spread of AMR outside the hospital published.	Project objective achieved More rational use of disinfectants reported (descriptive, no quantitative data). Routine monitoring of AMR established, leading to further ABS measures.	Project reports Interviews (GIZ)
Difäm/Liberia: Improved patient safety through development of knowledge management and a skills network for protection from AMR and infections in Liberian district hospitals	Outputs partially achieved (1) Significant improvement of hand-hygiene compliance (by up to 40%) in 2 of 3 partner hospitals. (2) Health staff training in patient safety (group webinars better accepted than the Health-Lernbox self-learning tool). (3) Increased staff skills in AMR and ABS, but formulation of related SOPs still pending.	Project objective partially achieved The three partner hospitals formulated and partially implemented IPC plans. Increased hand-hygiene compliance reduced the risk of nosocomial infections. However, monitoring of post-operative infections has not yet been established.	Project reports Interviews (German partner, GIZ)
Robert Koch Institute/Nigeria: Partnership on development of infection prevention and control protocols for infectious disease health emergencies (MAURICE)	Outputs achieved (1) A national protocol to improve patient safety during outbreaks and epidemic-prone diseases finalised (awaiting publication at the end of the project). (2) Facilitators and trainers of the Nigeria National Centre for Disease Control trained to deliver IPC training. (3) Staff of 14 hospitals trained to deliver IPC training.	Project objective achieved Operational research confirmed: (a) increased number of hospitals with IPC committees, (b) regular meetings of IPC committees taking place, (c) the presence of IPC focal persons on wards, including compliance with mandated activities (e.g. infection-control rounds) and (d) evidence that problems identified during infection-control rounds are dealt with.	Project reports Interviews (GIZ)

Robert Koch Institute/Côte d'Ivoire and Guinea: Partnership to Improve Patient Safety and Quality of Care in Guinea and Côte d'Ivoire (PASQUALE)	Outputs mostly achieved (1) Hygiene commissions were established, met regularly and agreed on improvement measures. (2) Training measures on hand hygiene were implemented, accompanied by situational analysis and documentation of disinfectant consumption. (3) Local production of disinfectants was launched. Quality improvement measures beyond hand hygiene were planned but were not possible in the time frame of the project; these will be pursued in a follow-on project financed by the German Federal Ministry for Health (see Section 4.6).	Project objective achieved A significant improvement in hand-hygiene compliance is documented for one hospital (Guinea) and expected but not yet measured for the other (Côte d'Ivoire). Availability and consumption of disinfectants increased based on local production (both hospitals).	Project reports
University Hospital Bonn/Tanzania: Improving patient safety in obstetric surgery	Outputs achieved (1) Six SOPs for obstetric surgery in one partner hospital and seven in the other, e.g. on IPC and peri- and post-operative monitoring, were formulated, and cases managed in accordance with the SOPs. (2) Interdisciplinary staff training for obstetric, anaesthetic and theatre staff was carried out. (3) Quality improvement circles for obstetric surgery were established.	Project objective mostly achieved The number of intra-operative and post-operative complications was reduced in both hospitals between 2018 and 2019 (from 30 to 11 cases and from 30 to 17 cases). Further clinical improvements were increased use of advanced anaesthetic methods for caesarean sections and establishment of a recovery room. However, due to human resources challenges, the quality circles were not performing as expected.	Project reports Interviews (German partner, African partner, GIZ)
University Hospital Düsseldorf/Ethiopia: Prevention and management of nosocomial transmission in Asella Teaching Hospital	Outputs achieved (1) A hygiene programme for the entire hospital was established, including supply of disinfectants (incl. local production), training for the entire hospital staff (92% coverage achieved), establishment of a hygiene and IPC unit and waste management. (2) An AMS team was established and SOPs for rational use of antibiotics formulated. (3) The microbiology laboratory diagnostics have improved (e.g. due to staff training, provision of consumables, formulation of SOPs).	Project objective achieved The incidence of nosocomial infection of inpatients decreased from 7.2% to 5.4% during the project term (among other factors, based on improved hand-hygiene compliance). Improved medical care for patients with severe infectious diseases was reported descriptively (no quantitative data).	Project reports Interviews (German partner, African partner, GIZ)
University Hospital Frankfurt/Kenya: Establishment of a surveillance system for healthcare-associated infections and a system for antimicrobial stewardship (AMS) at Kenyatta National Hospital, in partnership with the University Hospital Frankfurt am Main	Outputs partly achieved (1) An ABS team was established and trained. The intended AMR SOPs were not pursued after prioritisation of hand hygiene (based on a WHO hand-hygiene tool) was agreed. However, follow-up of hand-hygiene training was not possible within the project term due to restructuring of the IPC team.	Degree of project objective achievement unclear The partnership was consolidated, and ideas for future partnership activities were developed. For the current project, however, (clinical) changes at outcome level were not addressed in the final report.	Project reports Interviews (GIZ)

<p>University Medical Center Hamburg-Eppendorf/Côte d'Ivoire and Ghana:</p> <p>Optimisation of microbiology diagnostics and rational utilisation of antimicrobials</p>	<p>Outputs mostly achieved</p> <p>(1) Training and knowledge transfer activities were implemented as planned e.g. for laboratory services (microbiology diagnostics) and ABS. (2) Workshops and research activities (AMR in urinary tract infections) were held. (3) SOPs and further CD for laboratory diagnostics of blood cultures and urinary tract infections were introduced.</p> <p>Outputs were fully achieved in the Ghanaian partner hospital. They were achieved to a lesser extent in Côte d'Ivoire, due to closure of the partner hospital and the need to identify another partner hospital and rebuild working relationships and conditions.</p>	<p>Project mostly objective achieved</p> <p>Ghana: Improved routines for blood culture and urinary tract infection diagnostics and analysis of existing AMR were established; availability of consumables and timeliness of diagnostics improved (reported qualitatively, no data).</p> <p>Côte d'Ivoire: After initial progress, the partner hospital was closed. Urinary tract infection in the new partner hospital improved, but due to the shorter timeline did not achieve the same level (e.g. in analysis of AMR).</p>	<p>Project reports Interviews (German partner)</p>
<p>University Medical Center Hamburg-Eppendorf/Malawi:</p> <p>Increasing Patient Safety through Point-of-Care Ultrasound (POCUS) in Malawi – iPSUM</p>	<p>Outputs achieved</p> <p>(1) Equipment and consumables for point-of-care ultrasound (POCUS) were provided. (2) Health staff were trained and applied POCUS in routine care. (3) Use of POCUS was integrated in teaching activities at the College of Medicine, Blantyre, including a pool of trained trainers.</p>	<p>Project objective achieved</p> <p>Project objective indicators were basically identical to output indicators. However, reported data indicated the outcome was achieved, as POCUS was used to its full capacity, with approx. 50% of all ultrasound carried out by POCUS (for selected indications, e.g. pleurocentesis, 100%).</p>	<p>Project reports Interviews (German partner, GIZ)</p>
<p>Heidelberg University Hospital/Guinea:</p> <p>Improving patient safety in emergency health care and hospital management</p>	<p>Output achievement limited</p> <p>(1) Training on quality improvement was implemented. (2) Quality indicators for emergencies were developed. (3) Quality circles and peer-to-peer supervision were initiated.</p> <p>A lack of proactive leadership initiatives was reported, thus quality improvement processes did not function as expected (e.g. assessment tools and processes could not be developed). Due to rather generic written reporting, a more detailed analysis was not feasible.</p>	<p>Project objective not achieved</p> <p>Project reports do not provide details for a deeper analysis of goal attainment. However, the German partner stated in the final report that 2 years appeared to be too short a project time span to establish effective and sustainable processes and achieve tangible results.</p>	<p>Project reports Interview (GIZ)</p>
<p>University Hospital Munich (LMU)/Ethiopia/Tanzania:</p> <p>Tanzanian-Ethiopian-German network: improvement of diagnostics, treatment and management of patients through antibiotic resistance surveillance, ABS, and diagnostic process optimisation</p>	<p>Output achievement limited</p> <p>(1) Training activities on adequate use of antibiotics and identification of resistance patterns were implemented but the endline studies envisaged could not be carried out. (2) In the Ethiopian partner hospital, follow-up of patients for rational use of antibiotics was implemented, though without an endline study. The activity was not implemented in Tanzania. (3) An ABS team was established in Ethiopia (in Tanzania one was established by another development partner). (4) Training for laboratory staff (e.g. identification of AMR) was implemented but coverage was below target.</p>	<p>Project objective not achieved</p> <p>Due to lack of endline data, the project objective indicators (existence of documentation for rational use of antibiotics, satisfaction level of patients) could not be verified. In the final report, the German partner stated that the funding period was too short to get to meaningful conclusions. However, high levels of willingness to cooperate further in future AMR-related topics were reported for the partner in Jimma, Ethiopia, whereas the project in Mbeya, Tanzania was finally halted.</p>	<p>Project reports Interviews (GIZ)</p>

Rostock University Medical Center/Guinea: Partnership to increase patient safety in laboratory services: organisational and infrastructural improvement and further training in Guinea. Focus: laboratory services.	Outputs mostly achieved (1) Improved SOPs for laboratory diagnostics and improved methods for rapid identification of infectious diseases were introduced (with temporary infrastructural issues due to renovation works). (2) The Manchester Triage System for emergency care was introduced (incl. translation of guidelines into French). (3) Improved procedures for hygiene (e.g. infection-control rounds, instructions for cleaning staff), were partly challenged by limited availability of disinfectants.	Project objective mostly achieved Timeliness of laboratory diagnostics and communication to doctors and patients (particularly for urgent results) improved (qualitative reporting, no data). A system for detection of highly infectious diseases was applied. Due to external factors (renovation works, introduction of new laboratory software) results were not yet fully consolidated, but further support was available.	Project reports Interviews (German partner, GIZ)
Rostock University Medical Center/Cameroon: Partnership to increase patient safety in clinical services: organisational and infrastructural improvement and further education. Focus: clinical services.	Outputs mostly achieved (1) The Manchester Triage System for emergency care was operational in one of the two partner hospitals. (2) Improved procedures for hygiene (e.g. infection-control rounds, instructions for cleaning staff), with documentation of infection-control rounds still needed to be improved. (3) Laboratory work processes (e.g. guidelines for analytics, communication of results, waste management) were improved in both hospitals.	Project objective mostly achieved In one hospital, the laboratory was WHO-accredited and in the other the laboratory was close to fulfilling accreditation criteria. Timeliness of results communication improved (qualitative reporting, no data). There was reasonable coverage of the Manchester Triage application, though the need for further consolidation of routine processes was reported.	Project reports Interview (German partner)
University and Rehabilitation Hospital Ulm/Tanzania: Patient Safety Partnership (PSP)	Outputs mostly achieved (1) Situational analysis was carried out and improvement concepts for (a) waste management, (b) patient identity bracelets and (c) administration of medicines were formulated and implemented. (2) A blended-learning course for clinical staff (including practical projects for improvement of patient safety) was implemented, covering 74 participants (25% below the target of 100 trainees due to budgetary reasons).	Not evaluable Project reports were mainly output-oriented and did not provide sufficient information to assess the outcome of improvement measures and training. However, the potential for spill-over effects from the training to further hospitals was addressed (see Section 4.5 on impact)	Project reports Interview (GIZ)

Overall, output and project objectives were attained to a reasonable extent – bearing in mind that the goal levels were not uniformly applied and categorisation of results as outputs or outcomes required a certain amount of interpretation. Both at output and project objective/outcome level, 11 of the 15 partnerships mostly or completely achieved the intended outputs. According to their respective project reports, goal attainment was seriously hampered in only 2 cases, due to delays associated with institutional factors (such as leadership, regulatory delays, priority shifts associated with activities of other development partners). Whereas achievements at output level were well-documented, outcome-level results were mostly reported in a descriptive/qualitative manner, with 5 partnerships providing quantitative evidence.

In summary, target values for the (rather low-results-level) project objective indicators were fully achieved, except for the rather weak operationalisation of gender-sensitive activities, which remained limited to encouraging gender-balanced participation in project interventions. For the overall funding project portfolio, a reasonable degree of goal attainment was observed (with 11 partnerships fully or mostly achieving planned output and outcome objectives). Effectiveness dimension 1 – the project achieved the objective (outcome) on time in accordance with the project objective indicators – is rated at **35 of 40 points**).

Effectiveness dimension 2: the activities and outputs of the project contributed substantially to achieving the project objective (outcome)

- **Hypothesis 1:** The combination of financial grants and planning assistance provision (A-1) led to implementation of solutions for identified deficiencies in patient treatment and care (MI-1) and the related implementation of training measures (MI-2).

Generally, the IHPs were intended to function as long-term partnerships between German and African reference institutions cooperating sustainably in the mutual exchange of skills, knowledge and experience among the partners. On one hand, 9 of the 15 partnerships funded by the TC measure already existed prior to the evaluated funding round – though in some cases they used the funding project to include further partners (for example, Charité Berlin, which had already built up a relationship with a partner hospital in Uganda, now included a partner hospital in Sierra Leone to form a trilateral partnership). On the other hand, six projects brought together new partners, which established new ties through the funding projects. Though there are also other funding opportunities (such as the Global Health Partnerships TC measure), the particular characteristics of this TC measure (higher funding values, longer duration) facilitated establishment of stable ties with a sufficiently intense cooperation for a significant timespan (Ints 17, 18, 26, 28, 30). It can therefore be plausibly concluded that access to funding from the TC measure was a necessary precondition not only for implementation of the projects but also for establishment of some of the partnerships.

Among the previously existing partnerships, some even dated back decades (e.g. Munich/Tanzania to 1988, Heidelberg/Guinea to the 1990s). Many of these have received funding from multiple sources (e.g. DAAD, BMBF, the German Research Foundation (Deutsche Forschungsgemeinschaft), and in some cases, the patient safety projects supported by the TC measure built on previous interventions in similar thematic areas (e.g. several partnerships with antecedents in IPC). Nevertheless, regardless of the lifespan of the partnership, the availability of external funds was a necessary condition for developing meaningful implementation activities. Despite significant contributions (mostly personnel) from the German partners, cost items such as equipment and logistics could not be covered without external funding. It could not be ruled out that some partnership could have accessed alternative funding sources for selected interventions on patient safety. However, representatives of the German partners interviewed stated that their respective implementation activities would not have taken place without the funds provided by the TC measure (Ints 17, 18, 26, 28, 30).

Relevant technical contributions from GIZ were: (a) management of the competitive selection process for the project proposals, including definition of selection criteria and steering of the selection process (thus ensuring that funds were directed towards capable German and African reference institutions and well-focused projects),

(b) technical advice in planning methodologies and results-oriented reporting in accordance with a uniform format for all partnerships, and (c) organisation of network meetings and monitoring visits during the implementation process to ensure mutual learning among the partnerships and address any challenges associated with funds administration. Whereas the German project partners interviewed mostly highlighted the added value of networking meetings, methodological support was perceived as instrumental for standardised reporting rather than as contributing to the design or implementation quality of the projects (Ints 17, 26, 28, 30). German partners clearly focused on their clinical expertise as the basis for successful project design and implementation. From the available data, it is not fully clear if a stronger emphasis on results-oriented planning techniques could have added further value. On one hand, the project proposals and handling of the report formats revealed common methodological weaknesses (i.e. in formulation of indicators and the confusion of result levels, leading to a rather output-oriented reporting focus). On the other hand, the available evidence does not show whether more scrutiny on planning techniques would have added further value to implementation of clinical improvements, or rather that it is a formal issue that only affects the quality of documentation and reporting.

Overall, **hypothesis 1 is clearly confirmed**, since comparably meaningful interventions on patient safety could not have been carried out without the funding provided. Further added value from GIZ support was mostly attributed to the pertinent steering of project selection and support for networking among partners.

- **Hypothesis 2:** Implemented solutions (MI-1) and capacity development measures (MI-2) implemented by the partnerships have improved the conditions for patient safety in the target facilities (in regard to laboratory and hygiene capacities (O-1), quality management (O-2), quality of treatment and care (3), or other outcome categories as specified in the project plans).

Both result levels are documented for all projects in Table 3, with the output column covering the clinical solutions and CD measures implemented, and the outcome column covering the improved patient safety conditions in the target facilities. Overall, rather high goal attainment was observed at both levels.

Other than complex bilateral TC measures with multiple stakeholders, the university and hospital partnerships pursued highly specific objectives through a limited set of focused interventions within a confined organisational environment. Therefore, the straightforward results logic of the project was hardly exposed to other confounding variables, and contributions from third parties were mostly absent. The changes observed were therefore either the result of endogenous change processes or project interventions. In a few cases, where overlapping contributions from other development partners or national institutions were reported (e.g. Charité Berlin/Sierra Leone, LMU Munich/Tanzania), the respective outputs were abandoned to refocus on other interventions.

Due to the lack of interviews with African partner institutions, it was not possible to formally assess the potential for endogenous change (i.e. possible progress towards the intended results without external project support). However, taking into account (a) the complex contextual and organisational factors that caused the deficiencies analysed in the initial stage of the funding projects and (b) the portrayal of the change processes provided by the interviewees from German partner organisations (Ints 17, 18, 26, 28, 30), it is plausible to conclude that the reported results have mostly, if not completely, been catalysed by the access to funding, external expertise and capacity development contributions. This means that **hypothesis 2 is confirmed**.

- **Hypothesis 3:** The exchange of experience (B-4) and technical contributions (MI-3), combined with the TC support for coordination with relevant stakeholders such as development partners and the private sector (C-4), contributed to better linkage of the IHPs with other European and/or multi-lateral actors in the health sector.

The project stimulated exchange of experience and mutual learning through half-yearly network meetings (see GIZ 2020a), which all German partners interviewed highlighted as the most important contribution of GIZ tech-

nical assistance to the partnerships. Alongside these project-specific network meetings, formation of a thematically specific network on antimicrobial resistance (AMR network) was built into the project strategies of four partnerships (Charité Berlin/Rwanda, Munich /Ethiopia/Tanzania, Düsseldorf/Ethiopia, Hamburg /Côte d'Ivoire/Ghana). A fifth partnership (Frankfurt/Kenya) later joined the network. According to one of the final project reports, 'the newly established AMR network could emerge only through the support provided by GIZ' (see GIZ-IHP 2019h). Interviewees also maintained that the parallel funding of several projects in the same region and topic area and the networking support were decisive for the foundation of the network (Ints 2, 26, 32).

In addition to project activities carried out under the evaluated TC measure (AMR-network meetings; regional operational research on AMR in urinary tract infections in Rwanda, Tanzania, Ethiopia, Ghana, Côte d'Ivoire and Kenya; joint presentations at international conferences), the universities and hospitals involved pursued the establishment of a long-term partnership that would continue to promote AMR research and clinical attention to AMR in the region. In parallel, GIZ staff supported the network in creating further linkages (a) within GIZ with the regional TC projects on pandemic preparedness in the East African Community (EAC) region and the Economic Community of West African States (ECOWAS) region and (b) beyond GIZ with further potential funding agencies. During the project term, further funding of approximately EUR 60,000 to support scientific research within the network was acquired from the German Federal Ministry of Education and Research (BMBF).

The project also maintained communication with the German Academic Exchange Service (DAAD), in particular with the Partnerships for the Health Sector in Developing Countries (PAGEL) programme, which supports academic partnerships (e.g. curricula development, academic teaching/training, expert seminars). During the project term, one of the partnership projects (Heidelberg/Kenya) carried out a joint course on quality management with DAAD/PAGEL; another partnership (Munich/Tanzania) also received parallel funding. The Düsseldorf/Ethiopia partnership acquired DAAD funding for an Ethiopian PhD student, whose doctoral thesis is in the context of the regional research project of the AMR network mentioned above. In addition, the TC measure used national and international conferences and network meetings to disseminate information about the university and hospital partnerships and reach out to new partners, including from the private sector, leading to cooperation between Bayer AG and the Hamburg/Ghana partnership on a GIZ International Services project. The funding and project initiatives with BMBF and Bayer AG can be clearly attributed to GIZ networking support. Further proactive GIZ networking activities were also evaluated as very fruitful and supportive by the German partners interviewed (Ints 18, 26, 30). However, the university clinics involved already have their own excellent cooperation networks and funding relationships, which made it difficult to assess the significance of additional funding opportunities against the background of existing ties. **Hypothesis 3 is therefore partly confirmed.**

Overall, hypothesis 1 on the contribution of the TC measure to the implementation of patient safety interventions was confirmed and the counterfactual, that equivalent interventions might have taken place outside a funding programme, could be ruled out. Hypothesis 2 on the contribution of the project interventions to the clinical changes observed was also confirmed, since similar changes due to endogenous change processes are not plausible. Hypothesis 3 was partly confirmed, since there were several examples of additional linkages initiated by GIZ, though their significance against the background of the network relations of the university partners that already existed was difficult to assess.

Effectiveness dimension 2 – the activities and outputs of the project contributed substantially to achieving the project objective (outcome) – is rated at **26 of 30 points**.

Effectiveness dimension 3: unintended results

In the project reports and interviews with German partners, no unintended negative results and only a few unintended positive results were reported. Where additional results occurred, they were mostly not unintended in the narrower sense but can be traced back to adaptations of the original project designs at an early stage. For example, the Charité Berlin/Sierra Leone partnership switched from elaboration of an already existing IPC

training module to elaboration of training materials for core midwifery skills, which will be used in vocational training by the National School of Midwifery in Freetown and most probably in other midwifery schools in the country. In other cases, adjustments to training content or methodologies occurred due to context changes, but always in line with the original objectives. Finally, in a few cases, additional initiatives were reported; these were based on synergies with further external contributions (e.g. drilling new boreholes at the RKI's Guinean partner hospital – identified as a precondition for implementation of hand-hygiene measures and cofinanced with funds provided by a GIZ bilateral TC measure).

Though benefits for the Northern partners were not considered in the goal systems of the partnership projects, they are not unintended in the narrower sense but inherent in the principle of reciprocity. Benefits highlighted by German partners interviewed varied according to the clinical focus areas of the respondents and their institutions. Particularly for institutes specialising in tropical medicine and infectious diseases, field work in African countries was considered a contribution to their own (staff) capacity development and an opportunity for relevant operational research (e.g. on a global health challenge such as AMR). While research opportunities were high on the list of benefits for German partners, at the same time this area was highlighted as the area where horizontal cooperation between German and African partners was most pronounced (compared to the mostly unilateral knowledge transfer in clinical areas). Further aspects mentioned included: (a) offering field experience and research opportunities to junior staff, (b) enhancing experience on creative approaches for resource-poor settings and (c) strengthening (intercultural) soft skills (Ints 17, 18, 26, 28, 30).

At the overall steering level, the most important factor beyond the original methodological approach was the integration into the joint steering mechanism of the BMZ Hospital Partnerships – Partners Strengthen Health initiative, shortly after the project started. The pertinence of joint steering for the GIZ hospital partnership projects and the fit of the chosen format are discussed in Section 4.2. In addition, the absorption of significant personnel resources not calculated in the original instrument design came at the cost of reduced staff availability for closer monitoring of the partnership projects. An EA self-monitoring tool (EFFECT) promoted by the project was perceived as technically tedious and was therefore rejected by most partnerships. Although the project's personnel resources were not sufficient either to adjust the tool technically or instead to intensify other monitoring activities, such as field visits to the African countries, the German project partners raised no specific demands in regard to GIZ's monitoring function.

Taking in to account the absence of unintended negative results at the level of the funding projects on one hand and absorption of personnel resources for project monitoring by the steering mechanism of the BMZ initiative on the other, the assessment dimension is rated at **24 of 30 points**.

Criterion	Assessment dimension	Score and rating
Effectiveness	The project achieved the objective (outcome) on time in accordance with the project objective indicators.	35 of 40 points
	The activities and outputs of the project contributed substantially to achieving the project objective (outcome).	26 of 30 points
	No project-related (unintended) negative results have occurred – if any negative results occurred the project responded adequately.	24 of 30 points
	The occurrence of additional (not formally agreed) positive results has been monitored and additional opportunities for further positive results have been seized.	
Overall score and rating		Score: 85 of 100 points Rating: <i>successful</i>

4.4 Impact

The impact criterion covers (a) the extent to which overarching development results have occurred or are foreseen, (b) the contribution of the project outcome to achieved or foreseen overarching development results, and (c) the occurrence of project-related negative or additional (not formally agreed) positive results.

Evaluation basis and methodology for assessing impact

The assessment first analysed the extent to which the intended overarching development results were achieved or are foreseen (impact dimension 1). Since the project was a stand-alone project, there was no programme results framework with indicators for the impact level. The results model contains two different impact categories: (a) for patient-safety-related benefits for the target group and (b) for contributions to health-system strengthening. Due to the number and heterogeneity of the partnership projects, the limited value of individual grants, and the limited scope of the impact assessment, a contribution analysis for an outcome-to-impact hypothesis (impact dimension 2) did not focus on impact-level changes in the partner health systems, but on the impact on institutional strengthening by the funded partnerships and the resulting access to further financing:

- Better linkages between international health partnerships (IHPs) and other European and/or multilateral actors in the health sector (C-6), improved learning by the partnerships from project experience (B-4) and exchange of experience between partners (O-4) enabled the partnerships to better access cofinancing and other support from international development partners (I-4).

The analysis follows the same principles as those laid out in Section 4.3 for assessing effectiveness). The occurrence of unintended results (impact dimension 3) addresses both positive and negative results; the analysis also includes possible trade-offs between the different dimensions of sustainability.

The **methodology** for impact dimensions 1 and 3 was based on progress and final project reports, which were analysed for information on potential health-system strengthening (HSS) impacts. These were then discussed with representatives of selected German partner institutions and bilateral and regional GIZ projects. The contribution analysis also considered the results of interviews with representatives of other funding projects and agencies, and took into consideration that – except for one hospital – African partners could not be involved as originally planned.

Impact dimension 1: the intended overarching development results have occurred or are foreseen (plausible reasons)

- Health-related impact benefiting the target groups (patients) of the supported partner hospitals

The causes for risks related to patient safety (e.g. treatment errors, nosocomial infections, medication-related harm) are widely studied, and all 15 projects addressed well-known immediate causes of specific patient-safety deficiencies. Thus, by assessing project outcomes (see Section 4.3, Table 3), it could be plausibly assumed that attainment of the project objectives closely correlated with direct health-related benefits for patients, even though in most cases no further evidence was available for health-related indicators. In line with the funding purpose, research components of the funding projects were mostly dedicated to clinical research (e.g. on AMR patterns, medication efficacy), whereas evaluative baseline/endline measurements were limited to service-level variables (e.g. hand-hygiene compliance). Health-related data was reported by the following two projects:

- **Charité Berlin/Sierra Leone, project on safe obstetric care:** The facility-based maternal mortality rate in the partner hospital was reduced by 19% (i.e. from 1.66% to 1.34%) between 2016 and 2018. In the same period, the facility-based delivery rate for antenatal care clients increased by 25%.

- **Düsseldorf/Ethiopia, project on prevention of nosocomial infections:** Baseline and endline studies on nosocomial infection prevalence in Asella Teaching Hospital covered over 95% of the current inpatients, showing a 25% decrease in the infection rate (7.2% to 5.4% between 2018 and 2019).

In the case of Charité Berlin/Sierra Leone, the numbers were taken from the health management system and refer to a variable that is influenced by diverse other factors. As confirmed by the German and African partners interviewed, the magnitude of the drop in maternal mortality rates cannot be solely attributed to the project interventions, though there was a plausible influence. In the case of Düsseldorf/Ethiopia, on the other hand, the drop in nosocomial infection rates, confirmed by operational research, was assumed to be a specific project result.

All in all, it can be assumed that the degree of goal-attainment closely correlated with the extent of health-related impact, though evidence was only available for the cases mentioned above.

- Contributions to health-system strengthening beyond the African partner hospitals

The extent to which partnership projects had the potential to contribute to health-system strengthening (HSS) beyond the boundaries of the involved partner hospitals depended on several factors, in particular on (a) the role of the partner clinics within the health system (e.g. as reference or teaching institutions) and (b) the characteristics of the funding programme (e.g. the extent to which funding value and the resulting scope of interventions allowed for addressing spill-over effects in the project design). Whereas the potential of partnerships to generate impact *within* the partner hospitals was confirmed by a broad range of studies and evaluations, further health-system strengthening contributions (e.g. spill-over of skills and knowledge to other facilities, enhancement of teaching or training activities, feedback to health authorities) were often shown to play a minor role (see (GOPA 2020), for example).

In the case of the ESTHER university and hospital partnerships, however, the systemic relevance of the African partner institutions was a selection criterion for funding. Though related objectives were not systematically built into the goal systems, spill-over of skills and knowledge to further facilities was an implicit (in some cases also explicit) objective of many partnership projects. Documented potentials and/or results comprised the following:

- The partnership project of the RKI and the Nigeria Centre for Disease Control (NCDC) had national scope by design, including training provided to seven public and seven private hospitals and elaboration of a national protocol for outbreaks or epidemic-prone diseases. Operational research carried out 6 months after the training showed sharp increases in the number of active IPC committees, the presence of IPC focal persons in wards and compliance with infection-control rounds in the participating hospitals.
- Three cases involving African teaching hospitals documented, at least qualitatively, the potential for disseminating enhanced skills and knowledge to training participants and temporarily attached health staff from other hospitals (Charité Berlin/Ruanda, Düsseldorf/Ethiopia, Hamburg/Malawi).
- A further two cases involving regional or district referral documented potential to disseminate skills and knowledge to other facilities within their catchment area (RKI/Côte d'Ivoire/Guinea, Bonn/Tanzania). Two of these projects already involved participants from surrounding health centres in the training activities of the funding project or stimulated clinical attachments (RKI/Côte d'Ivoire/Guinea, Bonn/Tanzania).
- Two partnerships elaborated training materials, content or methodologies that have been implemented by further teaching/training providers or have the potential to be further disseminated (Charité Berlin/Sierra Leone, Ulm/Tanzania).
- Two partnerships initiated local production of disinfectants, either procuring the product for surrounding health facilities or facilitating knowledge transfer (RKI/Guinea/Côte d'Ivoire, Rostock/Guinea).

- Four partnerships were designed as trilateral partnerships to initiate South–South cooperation (e.g. training visits or exchange of health staff), thus providing opportunities for mutual learning.
- In four cases, impact potential beyond the boundaries of the involved hospitals was not reported.
- Finally, the five partnerships involved in the AMR network carried out joint research on AMR patterns, which contributed both to establishing ties for South–South cooperation between the African partners involved and to generating knowledge for more rational use of antibiotics.

(The total number exceeds 15, since some partnerships fell into several categories)

Overall, a rather high potential for health-related impacts was assumed within the African partner hospitals. Spill-over effects to further facilities or the spread of knowledge through South–South cooperation were documented or pursued by more than two thirds of the partnerships (11 of 15). The comparatively high potential for reaching beyond the boundaries of the partner institutions involved was confirmed as a particular strength of the ESTHER partnerships. A general limitation, however, was the lack of empirical evidence for the assumed impact-level results.

Impact dimension 1 – the intended overarching development results have occurred or are foreseen (plausible reasons) – is rated at **33 of 40 points**.

Impact dimension 2: the objective (outcome) of the project contributed to the occurred or foreseen overarching development results (impact)

- Better linkages between international health partnerships (IHPs) and other European and/or multilateral actors in the health sector (C-6), improved learning by the partnerships from project experience (B-4) and exchange of experience between partners (O-4) enabled the partnerships to better access cofinancing or other support from international development partners (I-4).

The contribution analysis in Section 4.3 (on effectiveness) already included the aspect of funding access, as most of the partnerships had strong networks of their own, so that value added to these networks could not be discerned other than by following additional funding relationships facilitated by the TC measure (in particular, funding or joint projects initiated with BMBF and the private sector, including Bayer AG). Therefore, the two hypotheses could not be separately assessed, and the rating given in Section 4.3 applies accordingly (the share of hypothesis 3 in the overall rating of effectiveness dimension 2 is 6 of 10 points.) Extrapolating to the assessment grid for this section, **impact dimension 2** – the objective (outcome) of the project contributed to the occurred or foreseen overarching development results (impact) – is rated at **18 of 30 points**.

Impact dimension 3: unintended results

No unintended negative results were observed or anticipated at impact level. As assessed under the relevance criterion, a majority of the projects had the potential to increase the capacity of the African partner hospitals to deal with the consequences of the coronavirus pandemic. More than half of the projects addressed general IPC and hygiene measures; two projects dealt specifically with patient and health-worker safety in epidemic outbreak situations. The potential of these partnerships to contribute to the coronavirus response could only be deduced from the successful implementation of their respective measures (see Section 4.3 on effectiveness) since there was no additional evidence for further assessment. Since no negative results occurred and positive additional impact can be at least plausibly assumed, this dimension is rated at **30 of 30 points**.

Criterion	Assessment dimension	Score and rating
Impact	The intended overarching development results have occurred or are foreseen (plausible reasons).	33 of 40 points
	The outcome of the project contributed to the occurred or foreseen overarching development results.	18 of 30 points
	No project-related (unintended) negative results at impact level have occurred – and if any negative results occurred the project responded adequately.	30 of 30 points
	The occurrence of additional (not formally agreed) positive results at impact level has been monitored and additional opportunities for further positive results have been seized.	
Overall score and rating		Score: 81 of 100 points Rating: <i>successful</i>

4.5 Efficiency

The assessment dimensions for efficiency refer to (a) the pertinent use of resources in regard to the outputs (production efficiency) and (b) the pertinent use of resources to achieve the project goal (allocation efficiency).

Basis and methodology for efficiency assessment

Both dimensions are based on a cost-benefit analysis. Costs were documented according to the cost-commitment report (*Kostenträger-Obligo Bericht*) and attributed to specific outputs, to provide an understanding of the relative cost-intensity of each output (the follow-the-money approach) and the appropriateness of the resource utilisation (efficiency dimension 1). Similarly, the extent to which outcomes could have been maximised with the same amount of resources (e.g. through different allocation among the targeted outputs) was analysed (efficiency dimension 2). For both assessment dimensions, the cost information and allocation decisions were analysed against the efficiency indicators as presented in the evaluation matrix.

The **methodology** was based on document analyses (e.g. project proposals, progress reporting, operational plans, cost-commitment report) and on interviews with project staff. For efficiency dimension 2 (allocation efficiency), interviews with representatives of bilateral and regional GIZ projects and German partner institutions added further value.

Efficiency dimension 1: the project's use of resources is appropriate with regard to the outputs achieved

The contract value for the whole duration of the project (June 2016 to November 2019) was EUR 4,000,000, of which approximately EUR 3.4 million was either spent or committed at the time of cost data collection shortly before the end of the project term. Transfer of remaining funds to the current funding cycle for e-health projects is planned. The largest share of the project budget was allocated to output 1 (support to partnership initiatives in the field of patient safety) – 76% of the resources spent, including 60% of the overall budget as funding value channelled to the German partner institutions as administrators of the project funds and 16% for GIZ technical responsibilities, such as steering the selection process, and administration of the funding mechanism. Output 2 (mechanisms for learning from IHPs on patient safety) also supported the partnership projects and received a further 15% of the overall budget, thus leaving 10% for output 3 (networking with further stakeholders, funding

agencies etc.). It must be taken into account that output 2 and output 3 included personnel input of approximately 7% of the budget value for co-steering the BMZ initiative (at the expense of both outputs and not originally planned for) and support to the ESTHER Secretariat (output 3).

The project was approved before the joint procedural reform of BMZ and GIZ, so that reporting was not subject to assignment of costs per output. The budget quoted was the result of the respective assignments drawn from the kick-off-workshop during the inception mission and estimations of output-specific expenses for each cost item. The shares were assumed to be quite precise for output 1 (funding value and related, clearly attributable costs for administration and technical inputs), and more of an approximation for outputs 2 and 3. Aside from the input required for co-steering the BMZ initiative, implementation of the outputs (and thus implicitly, though not yet formally planned for, the budget spending) followed the original design of the TC measure, except for the position of a long-term advisor in the project region, which was initially foreseen but not implemented. The decision to manage the TC measure solely with headquarters staff was taken prior to the start of the implementation, since the added value for a regionally dispersed portfolio was not convincing. Instead, one local GIZ health staff member was cofinanced as coordinator for liaison for the bilateral TC in Guinea and the local partnership projects, in view of the presence of three partnership projects in the same country. The decision clearly enhanced the quality of cooperation and coordination between the bilateral TC and the funding project in comparison to the situation in other countries (see efficiency dimension 2). The unspent residual budget resulting from the adjustment of the personnel concept will be transferred to the new TC measure on e-health. Apart from this early adjustment, the amounts for the grant contracts (output 1) and the related technical and administrative tasks were set, whereas the limited budgets for outputs 2 and 3 did not leave budgetary space for meaningful resource shifts. The additional tasks mandated by BMZ for co-steering the BMZ initiative further restricted outputs 2 and 3 to core activities. This compromised the availability of personnel resources for project monitoring in particular, while the synergies expected of the two TC measures under the roof of the initiative did not materialise as expected. Due to the limited budgetary space and adjustments driven mostly by external mandates, the **maximum principle** (i.e. the maximisation of outputs with the same amount of resources) is not meaningfully applicable to the project. It is possible that the modalities of the funding projects themselves (e.g. higher/lower funding values with a lower/higher number of funding projects) may have had an influence on the cost-output ratio. However, the evaluation did not provide comparative data to assess this factor.

In regard to **the output/resource ratio**, to ensure the results orientation of the funded projects, limits or threshold values for the maximum shares for staff costs and operational research and the minimum share for capacity development were set. Furthermore, the funding projects leveraged significant in-kind inputs from German and African partners, which were not quantifiable by the evaluation but were essential for implementation of all partnership projects. Whereas all German partners provided personnel resources, four German partners (five projects) even refrained from including any personnel costs in the project application. A further two partners (three projects) limited personnel costs to provision for the theses of postgraduate students, while clinical specialists were included as in-kind contributions only (see GIZ-IHP 2017a to 2017o).

Overarching costs were relatively minor. Activities commonly assigned to overarching costs (such steering with external actors, networking, knowledge management) were categorised under output 3. Seen from a genuine funding programme perspective instead of output distribution, 60% of the budget was assigned to the grants, 15% to technical contributions (output 2, e.g. monitoring), 16% to both technical contributions (e.g. management of the selection process) and administrative costs (e.g. contract management) both assigned to output 1. From this perspective, only 10% of the costs would be categorised as 'overarching' in the sense of being directly related to the grants. **Internal services from other GIZ units**, remunerated according to time recording (*Zeitaufschriebe*, ZAS), accounted for a total cost of EUR 90,027 at the time of data collection, i.e. less than 3% of the overall cost. Since relative costs (i.e. cost per time-unit) and most decisions for utilisation of services (e.g. by the sectoral department for the management of the change offer, by the financing department) were beyond the influence of the project management, and there was no time recording (ZAS) related to strategic inputs, the cost-benefit relation of ZAS is not relevant for the evaluation.

The **instrument design** was implemented as projected except for the decision to forego a long-term international advisor in the project region. There were no cost-related bottlenecks in regard to implementation of the instrument design. The personnel included five long-term advisors in Germany, complemented by short-term, third-party services from external consultants (planning support for grant recipients, preparation of project events, expert training, design of an online course on patient safety). The equivalent of one approximately half-time, long-term advisor each was allocated to co-steering of the BMZ initiative and support for the ESTHER Secretariat. Whereas participation in steering the BMZ initiative did not generate the expected synergies (see Sections 4.2 and 4.3), the support for the ESTHER Secretariat was assessed ambivalently by interviewees. On one hand, interviewees raised expectations of knowledge and information sharing and the sharing of experience between ESTHER partners as a basis for mutual learning and further development of each country's twinning approaches. On the other, during the timespan of the TC measure the countries involved tended to use ESTHER more as a platform for political dialogue. Though partners still adhered to the knowledge management function, it was not sustained with sufficient resources to maintain a meaningful dialogue. Against this background, the strategic or operational added value generated for the TC measure did not compensate for the opportunity costs of the half-time position allocated to the ESTHER Secretariat. More recently, however, and further catalysed by the search for responses to the coronavirus pandemic, there has been a tendency for partners to show more engagement in knowledge exchange through the ESTHER Alliance (Ints 2, 3, 7).

The evaluated funding cycle did not provide resources for integrated experts. However, one partnership was co-planned by an integrated expert from the German partner university that was financed by the bilateral GIZ health project. This constellation was highly beneficial for the partnership project, since the presence of long-term staff on site ensured (a) a thorough situational analysis in the pre-planning phase, (b) intense consultations with the African partners, and (c) access to professional on-site support between periodic short visits by German partner staff members. Since the expert was placed in an academic teaching position, a strong inter-connection between project-specific training activities and routine teaching activities was created, with benefits in both directions (availability of academic staff for project training, integration of training content into academic courses). The current TC measure on e-health is building on that experience and aims to create from three to five positions for integrated experts, with resources provided by the GIZ Studies and Experts Fund. The experience of the evaluated funding cycle cannot be fully extrapolated to the current funding cycle, since positions existing *prior to* a funding project, and positions created *during* an ongoing funding project have different potential (contributions to better preparation vs. to higher sustainability). While the potential for excellent synergies during the implementation process has been clearly illustrated, the biggest challenge consists in the timely placement of integrated experts whose positions cannot be created before specific partnerships are approved.

The **partner constellation** was pre-defined by the set project selection criteria; the **regional scope** was predetermined by the funds originating from the GIZ Regional Department for Africa. Since ranges for the grant amounts were also set, both aspects were not subject to any further management or allocation decisions. The appropriateness of related budgetary decisions is therefore not relevant for this evaluation.

Overall, the evaluation concludes that the share of resources applied to grants and related technical contributions was reasonable, i.e. the output/resource ratio is positive, whereas the **maximum principle** cannot be applied due to limited budgetary space for resource-shifting beyond core activities. For the same reason, being mandated to provide unscheduled personnel inputs to non-operational tasks gradually compromised performance in output 2. Altogether, **production efficiency** is rated at **55 of 70 points**.

Efficiency dimension 2: the project's use of resources is appropriate for achieving the project's objective (outcome)

The previous conclusion in efficiency dimension 1 above, that budgetary space and the given core tasks did not allow for meaningful resource reallocation *within* each output also applies for reallocation *between* outputs. Again, the **maximum principle** could not be applied for the evaluation.

Instead, a key criterion for allocation efficiency was the extent to which **synergies within the German development cooperation** were achieved. Potential interconnections with bilateral or regional TC projects in the health sector were explicitly addressed in the proposals of the partnership projects. The projects retained their legitimacy as stand-alone projects, at the same GIZ ensured that potential synergies were fostered and not overlooked. Thus, the initial ties identified ranged from sporadic informal communication and periodic information exchange to projects with immediate synergies and therefore close cooperation in GIZ project intervention areas. Examples of the latter category follow.

- In Guinea, a part-time (20%) national advisor position was cofinanced by the ESTHER project to facilitate the interconnection of three partnerships (involving RKI and the universities of Rostock and Heidelberg as German partners). Significant synergies were reported. The TC gave advice during the planning stage of the partnerships and during the implementation phases it contributed financial subsidies e.g. for procurement and infrastructural works in the partner hospitals. Among the synergies reported were: (a) plans by the bilateral TC project to scale up the local production of disinfectants initiated in the Faranah regional hospital (German partner: RKI), currently facing extremely high demand due to the coronavirus pandemic, and (b) transfer of IPC-related project experience from the RKI/Faranah and Rostock/Kindia projects to the IPC working groups of the country's Ministry of Health.
- In Tanzania, the University Hospital Bonn cooperated with regional hospitals in Lindi and Mtwara, which were also key project partners of the bilateral TC measure on MCH at that time. Whereas GIZ focused on quality-improvement processes and structures, the partnership project focused on specific clinical aspects in obstetric surgery. Both intervention areas were fully complementary and closely coordinated (Ints 17, 21). The case is also highlighted as a strategically well-planned synergy, since the partnership project was explicitly included in the protocol of prior government negotiations (Int 21).
- For Malawi, the positive implications of a CIM worker – placed by the bilateral TC project and filled by a specialist from the later German partner organisation – have already been outlined under evaluation dimension 1 (see section on instruments).

Among other factors, the potential for synergies is determined by (a) the proximity of the funding topic and the thematic orientation of bilateral or regional projects, (b) the methodological approach of the TC (i.e. the proximity to the clinical level), (c) the regional focus (i.e. the proximity of partnerships to the regional scope of bilateral projects and (d) the targeted sectors (e.g. public hospitals or faith-based hospitals). Depending on conceptual changes brought by follow-on measures, these factors may change over time. Unfortunately, there is a high risk that synergies appropriately identified at the beginning of a partnership project may decrease due to different timelines and related strategic changes to TC measures. For example, in the case of Tanzania, Lindi and Mtwara ceased to be partner regions of the bilateral project in early 2019, so that no further cooperation with their respective partnership projects could take place. Generally speaking, the synergies observed at the time of the evaluation fell somewhat short of the potential identified at the initial stages of the partnership projects.

Regarding **synergies with other development partners**, two levels must be differentiated: (a) the presence of other development partners at the level of the partnership projects and (b) the networking of the GIZ project with other potential funding partners and as member of the European ESTHER Alliance. Since the latter dimension is addressed by a specific output, it has been assessed in Section 4.3 and Section 4.4 (see also the respective hypotheses for the contribution analyses). At the level of the partnerships, no significant interconnections with other development partners were reported, which is to be expected given the narrowly focused clinical intervention areas of most partnerships. Therefore, the criterion does not add to the assessment.

As already mentioned in the previous section, **partner inputs** – from both German and African partners – were considerable. Limiting costs for personnel to 20% of the project financial value presupposed significant personnel contributions from the partnering institutions, further considering that six German partners (eight projects) provided all their personnel as in-kind contributions, without using the respective cost item, except for postgraduate research activities. The grants thus set considerable further partner contributions in motion.

In summary, there are positive examples for synergies between bilateral and regional TC measures and partnership projects. However, these synergies are perceived by both regional GLZ staff and German university partners as an optional area of opportunity instead of a consistent pattern. The leverage of German and African partner inputs is high and contributes to the positive overall rating of **allocation efficiency of 25 of 30 points**.

Criterion	Assessment dimension	Score and rating
Efficiency	The project's use of resources is appropriate with regard to the outputs achieved. (production efficiency).	55 of 70 points
	The project's use of resources is appropriate with regard to achieving the project objective (outcome). (allocation efficiency)	25 of 30 points
Overall score and rating		Score: 80 of 100 points Rating: <i>moderately successful</i>

4.6 Sustainability

The assessment dimensions of the sustainability criterion are (a) the extent to which results are anchored in partner structures and (b) a forecast of result durability of.

Basis and methodology for assessing sustainability

In regard to the degree to which results are anchored in partner structures (sustainability dimension 1), the evaluation considered (a) the extent to which capacity development results of the funding projects were anticipated to have a lasting effect on the capacities or health services of the African partner institutions, and (b) the extent to which the partnerships have benefited from the project in regard to consolidation and/or strengthening of the partnership as such. Sustainability dimension 2 is the core dimension of the sustainability criterion. The forecast refers to the results that have been identified under the effectiveness and the impact criteria. The analysis focuses on the prospects of the funding projects for achieving durable results. The **methodology** is based on analysis of the final project reports, and on interviews with representatives of the German partner institutions. The same methods and sources are used for the forecast of the durability of results. Whereas the available data was sufficient to assess mechanisms for anchoring results in the partner structures, the lack of interviews with African partners makes the forecast of results durability more unreliable.

Sustainability dimension 1: extent to which results are anchored in the partner structure

The extent to which funding project results are anchored in the partner structures had to be assessed against the background of each project's scope, which was mostly limited to focused clinical improvement. The expectation was not to observe complex organisational change, but the absorption of specific procedural or clinical changes by the African partner hospitals. The most common mechanisms identified from the project reports and the interviews with German partners were:

- elaboration of standard operating procedures (SOPs),
- integration of training content in the curricula of the training institutions involved,

- training of trainers or mentors,
- introduction of local production of consumables (in particular, disinfectants) needed to maintain the improvement achieved (here, hand-hygiene compliance) and
- establishment of self-learning or peer-learning mechanisms within the African partner hospitals (e.g. WhatsApp groups for peer consultation, electronic self-learning platforms).

More cross-cutting, management-related interventions, such as leadership training and the establishment of quality circles were also reported. However, these were evidently the most challenging measures, given the limitations on following up more complex interventions through intermittently spaced visits by the German partners. In this category, there were both successful examples (e.g. the enhancement of IPC teams and focal person structures in the 14 hospitals trained by the RKI/Nigeria NCDC partnership) and failures (see, for example, GIZ-IHP 2019k). Overall, roughly two thirds of the partnerships reported some of the mechanisms mentioned above. In one case, access to further technical support from another development partner was reported (GIZ-IHP 2019m). Three partnerships explicitly stated that the timespan for implementation was too short to create preconditions for lasting results (GIZ-IHP 2019h, 2019k, 2019l).

Overall, the partnerships have made significant efforts to foster institutionalisation of the project results. Project reports did not elaborate on the extent to which these mechanisms are consolidated. Some explicitly highlight the African partner's needs for further external support to keep the processes implemented running. Nevertheless, considering the scope of the type of cooperation, based on intermittently spaced peer visits, the potential for anchoring results in the partner structure have been exploited to a reasonable extent. **Sustainability dimension 1** – extent to which results are anchored in the partner structure – is rated at **40 of 50 points**.

Sustainability dimension 2: anticipated durability of results

In regard to the anticipated durability of results, the analysis had to distinguish between the durability of project results and the durability of the partnerships, considering that the purpose of the funding can be seen from two different, equally legitimate, angles. On one hand, funding under the ESTHER TC measure focused on highly specialised institutions and released resources to achieve specific development objectives, i.e. strong partnerships were used as a vehicle for achievement of specific, project-related grant purposes. On the other hand, establishment and strengthening of partnerships is also a purpose in itself (see the respective targets in the BMZ Marshall Plan for Africa, BMZ 2017b); seen from this angle, project grants are a vehicle contributing to sustainable North–South cooperation among health institutions.

At the partnership project level, sustainability was assessed rather critically. Even some projects with high goal attainment (see Section 4.3, Table 3) and successfully developed mechanisms for integration of improvements into the partner structure (see previous section) assessed sustainability expectations rather critically and highlighted the need for further consolidation of results and continuing support to the African partners. Interviewees regarded the timespan of the TC measure – which allowed for approximately two years net implementation time – as sufficient for achievement of the operational goals but rather too short for consolidation of related managerial processes and stabilisation of work routines (Ints 17, 18, 26, 28, 30). In particular, high staff turnover in most of the African partner hospitals was seen as key factor that required a certain level of 'built-in redundancy' in CD measures (e.g. strong cadres of trained trainers, mentors and a critical mass of trained personnel) to compensate for expected losses of trained personnel. However, most interventions were well-adapted to low-resource settings, which meant that (a) the solutions identified could function in such settings and (b) known challenges, such as procurement of consumables, were dealt with as far as possible (e.g. local production of disinfectants, equipment that can be maintained locally). Nevertheless, 9 of the 15 partnerships expressed concerns about the self-sustainability of the results achieved (including partnerships that did not report on sustainability expectations and did not achieve the intended results, see Section 4.3). They also highlighted the long-term cooperation perspective as a factor of paramount importance for achieving sustainability.

Against this background, BMZ's decision to change the funding topic from patient safety to e-health was harshly criticised by many partners, either in final reports or in interviews held for the evaluation. While some interviewees emphasised that patient safety as a funding topic is more relevant to the regional context than e-health (Ints 8, 14, 17, 18, 20, 21, 28), others recognised the innovative potential and its thematic openness to a broader range of clinical areas, which could also include further efforts in the area of patient safety (Ints 10, 11, 18, 26). However, feedback that it would have been better to involve stakeholders in prior consultations rather than to suddenly communicate this unexpected thematic shift was predominant.

This aspect is directly related to the second aspect of sustainability, i.e. the sustainability of the partnerships. As explained above, most partnerships are functioning with a long-term perspective but still require a stable flow of consecutive funding for meaningful implementation activities (Ints 4, 16, 18, 28). Seven of the partnerships that engaged in patient-safety projects submitted successful proposals for the new funding cycle (mostly continuing in similar clinical areas); among these are four of the partnerships mentioned above that stressed the need for continued support to ensure the sustainability of the previous project outcomes (see project list, GIZ 2020b). A high proportion of these are partnerships involved in the AMR network, which presented their proposals under one overarching project topic (COMBAT AMR in Africa network), now being implemented through five closely interconnected funding projects. Several other partnerships of the evaluated funding cycle also presented proposals, which finally failed to be accepted (GIZ 2020b, Ints 17, 28, 33).

Among the eight partnerships that have not received further funds from the new ESTHER TC measure, one has acquired funds from the German Federal Ministry of Health (BMG) to carry out a genuine follow-on project. With a funding amount of EUR 250,000, the RKI and its partners in Guinea and Côte d'Ivoire are now implementing interventions focusing on safe surgery (BMG 2020). The German Institute for Medical Mission (Difäm) has also obtained financing for another three-year project on IPC and AMR, adding further partners to the network established under the ESTHER TC measure. Among the remaining partnerships that are not continuing under the new funding TC-measure, one German university involved in two long-standing partnerships expressed optimism about the possibility of future funding for both. Currently, a funding proposal has been submitted to Health Partnerships Global) and the possibility of bridging the external funding gap in the short and medium term through occasional, transitional activities (e.g. by master's or doctoral students, or even private trips) as 'each interaction counts' (Int 28). No updated information is available for two partnerships, while one partnership – newly established for the purpose of the safety project – has now terminated (Int 17).

Altogether, most interviewees focused on sustainability at the level of the partnerships, seeing this as a necessary precondition to achieving sustainability for project-specific results. While partners clearly expressed their concerns about project-related sustainability, a high proportion were either implementing or planning further interventions. Again, it must be pointed out that dependency on external funds for meaningful interventions is a given. **Sustainability dimension 2** – anticipated durability of results – is rated at **35 of 50 points**.

Criterion	Assessment dimension	Score and rating
Sustainability	Prerequisite for ensuring the long-term success of the project: results are anchored in (partner) structures.	40 of 50 points
	Forecast of durability: results of the project are permanent, stable and resilient in the long term.	35 of 50 points
Overall score and rating		Score: 75 of 100 points Rating: moderately successful

4.7 Key results and overall rating

Relevance: The project was consistently aligned with the relevant strategic reference frameworks at all levels (German development cooperation, international standards and guidelines, sector strategies of partner countries), considering the communication challenge of discerning the approaches and strategic orientation of the two TC measures for hospital partnership funding. The core problem, and thus the funding topic, is highly relevant, and the specific interventions of the funding projects corresponded to the problems and needs of the African partners. Gender mainstreaming aspects were limited to gender-balanced participation only and did not reflect gender-transformative aspects. The generic formulation of the indicators of the project objective was pertinent for the type of programme and adequately complemented by the project assessment criteria and technical support from GIZ for the partnerships. Despite some methodological shortcomings in the application of common TC planning mechanisms, the funded partnerships were also clearly focused on clinical changes, sustained by plausible intervention packages. The establishment of a joint steering mechanism for the BMZ Hospital Partnerships – Partners Strengthen Health initiative did not generate the expected added value for coordination of the two integrated TC-measures (**rating: successful**).

Effectiveness: The project achieved the project objective indicators: (a) solutions for improvement of patient safety have been implemented in all partnerships except for the rather weak operationalisation of ‘gender-sensitive solutions’, (b) training measures have been implemented in all partnerships and (c) publications and presentations at international network meetings exceeded the target. For the funding project portfolio, a reasonable degree of goal attainment was observed. Changes observed in African partner hospitals were clearly attributable to the project interventions. While some networking support results were evidently catalysed by the project (e.g. the AMR network), partner institutions also tended to have their own strong networks (**rating: successful**).

Impact: Whereas the health-related benefits of most interventions were plausible, only two partnerships provided data on impact level variables. More than two thirds of the partnerships (11 of 15) documented or pursued spill-over effects to further facilities and the spread of knowledge through South–South cooperation, though this was mostly not supported by data. Nevertheless, the comparatively high potential for reaching beyond the boundaries of the involved partner institutions is confirmed as a particular strength of the ESTHER partnership. A majority of the projects worked on topics relevant for mitigation of the coronavirus pandemic (**rating: successful**).

Efficiency: The share of resources applied to grants and related technical contributions was reasonable, i.e. the output/resource ratio was positive, whereas the maximum-principle could not be applied due to limited budgetary space for resource-shifting beyond core activities. For the same reason, the mandate to provide unscheduled personnel inputs to non-operational tasks (co-steering of the BMZ-initiative) gradually compromised performance in output 2 (e.g. monitoring of partnership projects). There were positive examples of synergies between bilateral or regional TC measures and partnership projects. However, both regional GIZ staff and German university partners perceived these synergies as an optional area of opportunity instead of a consistent pattern. The leverage of German and African partner inputs was high (**rating: moderately successful**).

Sustainability: The partnerships undertook significant efforts to foster institutionalisation of the intended project objectives, though project reports did not elaborate on the extent to which these mechanisms were consolidated; some explicitly highlighted the African partners’ needs for further external support to keep implemented processes running. Most interviewees tended to focus on sustainability at the level of the partnerships, seeing this as a necessary precondition for achieving sustainability for project-specific results. While partners clearly expressed their concerns about project-related sustainability, a high proportion of the partnerships were either implementing or planning further interventions (**rating: moderately successful**).

Criterion	Score	Rating
Relevance	87 of 100 points	Successful
Effectiveness	85 of 100 points	Successful
Impact	81 of 100 points	Successful
Efficiency	80 of 100 points	Moderately successful
Sustainability	75 of 100 points	Moderately successful
Overall score and rating for all criteria	81.6 of 100 points Average score for all criteria (sum divided by 5, max. 100 points see below)	Successful

100-point-scale (score)	6-level scale (rating)
92–100	Level 1 = highly successful
81–91	Level 2 = successful
67–80	Level 3 = moderately successful
50–66	Level 4 = moderately unsuccessful
30–49	Level 5 = unsuccessful
0–29	Level 6 = highly unsuccessful

5. Conclusions and recommendations

5.1 Key findings and factors of success/failure

The factors for success or failure summarised below are (a) factors at partnership level and (b) factors at the level of the overall TC measure (according to the success factors of the GIZ Capacity WORKS model).

Success factors for the partnerships and partnership projects

Institutional health partnerships have a long history, and past studies and evaluations have generated broad knowledge on a range of success factors. An ESTHER Alliance literature review summarises a list of 45 success factors identified in 44 published and grey literature documents on IHPs (see EA 2015a, p. 17), in particular highlighting: (a) emphasis on Southern ownership and demand orientation, (b) alignment with national strategies, (c) quality of communication, (d) monitoring and feedback mechanisms, (e) the longevity of the partnership and access to sustained funding, (f) personal commitment and cultural sensitivity, (g) project management support to clinicians, (h) equality/reciprocity between partners. A recent accompanying evaluation of the BMZ Initiative for Hospital Partnerships (see GOPA 2020) also summarises a similar set of success factors. However, the success factors mentioned mostly apply in the same way for partnerships projects funded through the evaluated TC measure:

- The importance of a long-term perspective was stressed by all IHP partners interviewed (Ints 17, 18, 26, 28, 30). While short-term project goals were achieved by well-established as well as new partnerships, the sustainability of results was strongly associated with the longevity of the partnerships. As a downside, full dependence on project financing posed a challenge, not necessarily for maintaining long-term relationships but for the sustainable capacity development of African partners.
- Needs orientation through participatory definition of project goals and initial situational analyses was key for ensuring ownership by the African partner institutions (see Section 4.2, relevance dimension 2). Less successful partnership projects (see Section 4.3, Table 3) were partly associated with difficulties in adjusting interventions to the context.
- Due to comparatively high funding amounts, the scope of CD approaches was significant. As well as task-specific peer-to-peer knowledge and skills transfer, training in many partnerships took into consideration sustainability aspects (e.g. training of mentors), multiplier effects (e.g. training of trainers), risk factors (e.g. training with 'built-in redundancy' so as to reach a critical mass in response to high staff turnover) and different staff levels (e.g. leadership, doctors, nurses, cleaning staff) (see Section 4.3).
- Most of the projects had a realistic, clearly defined scope, avoiding – with few exceptions – overambitious goals for the type of project (characterised by a net duration of approximately 2 years, based on intermittent punctual interventions) (see Section 4.3, Table 3).
- Whereas the clinical components of the partnership projects clearly focused on North – South knowledge and skills transfer, operational research components involved German and African partners in a more equitable way and generated added value for both parties, thus sustaining the principle of reciprocity (see Section 4.3, effectiveness dimension 3).
- Critical factors leading to delays or performance losses included: limited duration of the funding period, high staff turnover, adverse external events (e.g. unrest or strikes), institutional commitment affected by changes in leadership, administrative challenges, complicated procedures for importing goods procured for projects and limited availability of personnel resources from German partners beyond the initially specified in-kind contributions (see GIZ-ISP 2019a-o, Ints 17, 18, 26, 27, 28, 30).

Strategy

- The patient safety funding topic was considered highly relevant, because: (a) it represented a global health challenge, (b) it was particularly relevant to the target region and (c) it provided a strategic focus while being sufficiently broad to allow for initiatives in different clinical areas. Respondents who criticised the thematic shift towards e-health did so because they preferred a health-related over an 'instrumental' topic, or because they questioned the readiness of the partner region for the e-health focus. While the preference for a health-related funding topic was widespread, opinions on the regional pertinence of the new funding topic diverged, with some interviewees highlighting the benefit of exploring regionally adjusted technologies (see Section 4.2, relevance dimension 1).
- The focus on German and African reference institutions (including teaching and referral hospitals and other teaching institutions among the African partners) implied numerous linkages to other segments of the health systems (see Section 4.4, impact dimension 1). Though the key focus of most projects was still bilateral or trilateral and empirical evidence for spill-over or systemic effects was weak, enough interconnections were observed to confirm the potential of reaching beyond the boundaries of the partner institutions involved. Consecutive funding would probably help to expand and replicate the results of a project in other hospitals and/or departments.

Steering

- The criteria-based selection process and related technical support ensured: (a) the relevance of the selected projects in relation to the funding topic, (b) selection of German partners with high levels of

expertise and African partners with systemic relevance, (c) consideration of synergies with the bilateral or regional TC portfolio (see also cooperation below) and (d) the transparency of the selection process (see Section 4.3 effectiveness dimension 2).

- Despite set criteria for planning, monitoring and reporting and related support from GIZ staff, goal systems and reporting quality still varied considerably among the projects (see Section 4.2, relevance dimension 3). To a certain extent, it is acceptable that the hospitals involved cannot be measured by existing quality standards for TC measures. However, stronger emphasis on outcome-oriented monitoring and reporting should be considered.
- The co-steering of the BMZ Hospital Partnerships initiative did not generate the expected synergies between the two TC measures of GloBe and the GIZ Regional Department for Africa. In addition, the originally unscheduled personnel inputs gradually compromised inputs in operational tasks (e.g. monitoring of partnership projects) (see Section 4.5, efficiency dimension 1).

Cooperation

- GIZ's ability to link IHPs to the bilateral and regional TC portfolio is a strong comparative advantage. Though the potential for synergies varies according to the focus of TC measures and interconnections may be affected by divergent project terms (see Section 4.5, efficiency dimension 2), some good practice examples show that linking IHPs and TC measures is at least a significant area of opportunity.
- The support of the TC measure to networking between partnerships (network meetings, funding of tri-lateral partnerships) was highly appreciated by the German partners interviewed (see Section 4.3, effectiveness dimension 2). The AMR network in particular is an example of good practice for combined North–South and regional cooperation on a transnational health challenge.

Learning and innovation

- Financed by the TC measure, the University of Heidelberg developed an e-learning course on patient safety in clinical and resource-poor settings, which is now formally integrated in the university's teaching programme on social protection and quality improvement. The course builds upon experience gained during the evaluated funding cycle and reaches out to target groups beyond the beneficiaries of the funded projects. During its first year of operation, GIZ staff can participate free of charge.

5.2 Conclusions and recommendations

Based on the findings presented in Chapter 4 and the success factors summarised in Section 5.1, six aspects are highlighted as key recommendations for the continuity and further development of support to institutional health partnerships by BMZ and GIZ:

- **Continuity of the funding of university and hospital partnerships:** According to the results of the evaluation, the university and hospital partnerships showed significant potential (a) to leverage expertise otherwise unavailable to the German development cooperation and (b) to strengthen key African partners with plausible and observable spill-over and multiplier effects on other segments of their health systems. At the same time, further funding prospects are an important precondition for the impact and the sustainability of the partnerships. Therefore, the evaluation concludes in recommending continued funding of university and hospital partnerships.
- **Continuity of focused but sufficiently flexible funding topics:** The patient safety funding topic provided a clear strategic focus around several global health challenges as defined by WHO (IPC, epidemic preparedness, AMR) while at the same time allowing for a broad spectrum of project measures

and convergence of several projects around key topics (see Section 4.3). Most interviewees agreed that setting overarching topics for future funding cycles using similar criteria was also pertinent.

- Identification of partnerships during the appraisal instead of an ‘in-project’ selection process:**
 Due to the time consumed by the competitive selection process, the net time-span for implementation was reduced to approximately 2 years, considered too short by several participants for consolidation of management processes and stabilisation of new work routines in the African partner institutions. To fully exploit the three-year project term of a TC module, partnership projects could be identified during the appraisal of the TC module, thus eliminating the need for complex selection process during the project term and maximising the time frame available for implementation of the partnerships projects. Extrapolating from the positive experience with the AMR-network, focusing on established (thematic) networks of partnerships could enhance synergies.
- Interconnections and boundaries between the two TC-measures for the funding of IHPs:**
 Whereas the two TC measures for the funding of IHPs have clearly distinct characteristics, the complementarity and/or boundaries between the two approaches have not yet been fully conceptualised (e.g. in regard to conceptual dilution due to parallel funding to institutions by both modules, see Section 4.2). However, further exploration of the interconnections and boundaries between the two funding mechanisms does not imply returning to the formalised co-steering, where cost/result ratio did not meet expectations (see Section 4.5)
- Synergies with other TC-instruments:** The presence of integrated experts in related institutional and technical areas has proven potential to benefit partnership in several aspects such as (a) facilitation of the participatory, needs-based project design (if an expert is in place prior to the partnership project), (b) continuity of project activities between intermittent visits by German partners, (c) strengthening of interconnections between projects and health systems (here exemplified by an integrated expert in a teaching institution) and (d) increasing the scope of CD components of partnership projects (see Section 4.5). Complementing partnership projects with integrated experts is therefore highly encouraged.

It must be kept in mind, however, that the case analysis in this evaluation refers to an opportunity-driven synergy with an integrated expert who was already in place during the design phase of the partnership project, whereas currently envisaged placements financed by GIZ's Studies and Experts Fund presuppose that partnership projects have already been selected. Under the current selection modality, a time lag between project selection and expert placement is unavoidable, whereas identification of partnership projects during the appraisal process of a future module would allow for aligning expert placements with project implementation periods.

- Dissemination of experience gained and lessons learned within the German development community:** While direct peer-to-peer networking and exchange of experiences was facilitated by GIZ's technical support, interviews with GIZ staff in bilateral and regional projects revealed a demand of further information on good practices, experience gained and lessons learned from hospital partnerships (e.g. Ints 8, 19, 29). Though this unsatisfied demand may have partially resulted from the project's timeline (i.e. the aggregated processing of results of the evaluated funding cycle was still on-going) and the turnover of GIZ staff in the project region (see Section 4.5), the evaluation recommends that further emphasis is given to proactive communication of knowledge gained from partnership projects to the German development community. Since knowledge products of partnerships tend to be available towards (or even after) the end of the funding project cycle, the knowledge management provided by GIZ transcends the boundaries between consecutive TC modules. Thus, effective knowledge management partly depends on the continuity of funding.

Annex

Annex 1: List of resources

Standard documents: Offer and related documents

GIZ (2016a): Offer for implementation of a regional TC measure “Institutional Health Partnerships in Africa”, PN 2016.2035.0, May 2016.

GIZ (2016b): Project proposals and funding contracts of the 15 selected partnership projects.

GIZ (2018a): Change offer for the regional TC measure: „ESTHER-Alliance – Strengthening University and Clinic Partnerships in the health sector“ in Africa, PN 2016.2035.0.

Standard Documents: Reporting and Monitoring

GIZ (GIZ-IHP 2017a to 2017o): Project Proposals for the university and hospital partnership projects.

GIZ (2017a): Fortschrittsbericht zu einer alleinstehenden TZ-Maßnahme ‚Afrika NA – ESTHER-Allianz: Hochschul- und Klinikpartnerschaften im Bereich Gesundheitssystem stärken‘, Afrika NA. Berichtszeitraum 01.06.2016 – 31.07.2017.

GIZ (2018b): Fortschrittsbericht zu einer alleinstehenden TZ-Maßnahme ‚Afrika NA – ESTHER-Allianz: Hochschul- und Klinikpartnerschaften im Bereich Gesundheitssystem stärken‘, Afrika NA. Berichtszeitraum 01.06.2017 – 31.07.2018.

GIZ (2019b): Regionalprogramm Hochschul- und Klinikpartnerschaften in Afrika, PN 16.2035.0-001.00. Power-Point-Presentation, Eschborn, 04.11.2019.

GIZ (2019c): Erfolgsfaktoren von Förderprogramm. Erste Schlussfolgerungen. Power-Point-Presentation, Eschborn, November 2019.

GIZ (2020a): Fortschrittsbericht zu einer alleinstehenden TZ-Maßnahme ‚Afrika NA – ESTHER-Allianz: Hochschul- und Klinikpartnerschaften im Bereich Gesundheitssystem stärken‘, Afrika NA. Berichtszeitraum 01.08.2018 – 30.11.2019.

GIZ (2020): Projektliste für die Förderrunde für Hochschul- und Klinikpartnerschaften im Themenfeld eHealth.

GIZ (GIZ-IHP 2018a to 2018o): Progress reports for the university and hospital partnership projects during the year 2018.

GIZ (GIZ-IHP 2019a to 2019o): Progress reports for the university and hospital partnership projects during the year 2018, including final reports.

Standard documents: Quality-assurance-in-line, Capacity Works and related documents

GIZ (2016c): Akteurslandschaft, Hochschul- und Klinikpartnerschaften – ESTHER (2016).

GIZ (2016d): Überblick Struktur der Kernprozesse, Hochschul- und Klinikpartnerschaften – ESTHER.

GIZ (2016e): Überblick Rahmenbedingungen, Hochschul- und Klinikpartnerschaften – ESTHER.

GIZ (2016f): Wirkungsmodell, Hochschul- und Klinikpartnerschaften – ESTHER.

GIZ (2019d): Leitfaden für die Erstellung und Abwicklung von Finanzierungsverträgen, Stand März 2019.

GIZ (2019e): Operationsplan, Hochschul- und Klinikpartnerschaften ESTHER, 2016-2019.

Strategy documents of the German Development Cooperation and ESTHER Alliance, International Agreements

BMZ (2009a): Sector Strategy „German Development Policy in the Health Sector“. BMZ-Strategies 187, August 2009.

BMZ (2014a): The BMZ's New Africa Policy – from a continent of crises to one of opportunities. BMZ Paper 6/2014.

BMZ (2016a): The BMZ's Africa Policy – New challenges and focuses. BMZ Paper 4/2016.

BMZ (2017a): Der Zukunftsvertrag für die Welt. Die Agenda 2030 für Nachhaltige Entwicklung. BMZ, März 2017.

BMZ (2017b): Africa and Europe, A new partnership for development, peace and a better future, Cornerstones of a Marshall Plan with Africa. BMZ, January 2017.

BMZ (2019a): Web portal of the ‚Initiative Klinikpartnerschaften‘. Retrieved under: <https://www.klinikpartnerschaften.de/initiative#unser-ziel> (last access: December 1, 2019).

BMZ (2019b): Global Health – An investment in the future. BMZ position paper, 02/2019.

Bundesregierung der Bundesrepublik Deutschland (BR 2015): DART 2020 – Antibiotika-Resistenzen bekämpfen zum Wohl von Mensch und Tier, Beschluss des Bundeskabinetts vom 13. Mai 2015, erstellt durch das Bundesministerium für Gesundheit, das Bundesministerium für Ernährung und Landwirtschaft sowie das Bundesministerium für Bildung und Forschung.

Bundesregierung der Bundesrepublik Deutschland (BR 2018): Globale Gesundheitspolitik, Staatssekretärsausschuss für nachhaltige Entwicklung, Beschluss vom 29. Oktober 2018.

European ESTHER Alliance (EA 2015a): Charter Quality of Partnership, adopted by the EEY Board the 27th of February 2015.

European ESTHER Alliance (EA 2015b): Strategic Framework of the EA 2015-2020. Paris: EA.

G20 (2017): Berlin Declaration of the G20 Health Ministers – Together Today for a Healthy Tomorrow. Berlin, May 19-20, 2017.

UHC 2030 International Health Partnership (UHC 2017): Healthy systems for universal health coverage – a joint vision for healthy lives. Published by the World Health Organization and the World Bank.

United Nations (UN 2015): Transformation unserer Welt – die Agenda 2030 für nachhaltige Entwicklung.

World Health Organization (WHO 2002): Quality of care – patient safety, Resolution WHA 55.18 as of May 18, 2002.

World Health Organization (WHO 2007): International Health Regulations (2005) – Areas of work for implementation, June 2007.

World Health Organization (WHO 2006): London Declaration – Patients for Patient Safety, WHO World Alliance for Patient Safety. March 29, 2006.

World Health Organization (WHO 2012): African Partnerships for Patient Safety, Improving patient safety – Partnership Preparation Package, A resource for all health partnerships committed to strengthening patient safety”. WHO, November 2012.

World Health Organization (WHO 2014): Guidelines for Developing National Patient Safety Policy and Strategic Plan. Patient Safety Unit / Health Systems and Services Cluster, WHO African Region, December 2014.

World Health Organization (WHO 2015): Global Action Plan on Antimicrobial Resistance. WHO: 2015.

World Health Organization (WHO 2016a): Global strategy on human resources for health. Workforce 2030. WHO: 2016.

World Health Organization (WHO 2016b): Twinning partnerships for improvement. Recovery Partnership Preparation Package. Building capacity to reactivate safe essential health services and sustain health service resilience. WHO: 2016.

World Health Organization (WHO 2017): Patient safety – Making health care safer. WHO: 2017.

Literature, studies and evaluations on hospital partnerships

Citrin, David et al. (2017): Power, potential, and pitfalls in global health academic partnerships. Review and reflections on an approach in Nepal. In: Global Health Action, Vol 10, 2017.

Eckerle, Michelle et al. (2017): Building sustainable partnerships to strengthen paediatric capacity at a government hospital in Malawi. Community Case Study, published by frontiers in Public Health, July 2017.

Edwards, Suzanne (2015): Towards a simple typology of international health partnerships. In: Globalization and Health, 11/2015.

Edwards, Suzanne (2016): Evaluation of an established international health partnership using theory of change. A report commissioned by THET.

European ESTHER Alliance (EA 2013a): Evaluation Report. European ESTHER Alliance – Study, May 2013.

European ESTHER Alliance (EA 2014a): Case Studies. Partnerships Implemented with the Support of France, Germany, Ireland, Italy, Norway and Spain.

- European ESTHER Alliance (EA 2014b): The ESTHER Alliance's Regional African Workshop. The institutional health partnerships-based approach, November 2014.
- European ESTHER Alliance (EA 2015a): Review on effectiveness of institutional health partnerships. Liverpool: EA, February 2015.
- ESTHER Switzerland (2018): External Evaluation of the ESTHER Switzerland Program – Term of Reference.
- ESTHER Switzerland (2019): External Evaluation Report. By Public Health Services (Claudia Kessler), March 27, 2019.
- GIZ (2015a): Partnerships for better patient care. How ESTHER Germany supports the twinning of African and German hospitals. German Health Practice Collection, November 2015.
- GOPA (2020): Accompanying evaluation of the Initiative “Hospital Partnerships – Partners Strengthen Health”, Annual Report 2019, by Jens Koy, Silke Gräser, Tobias Schmolke.
- Jones, Andrew (2016): Envisioning a Global Health Partnership Movement. In: Globalization and Health, 1/2016.
- Kelly, Ema et al. (2015): A rapid review on the effectiveness of institutional health partnerships. In: Globalization and Health, 11/2015.
- Kulasabanathan, Hamdi Issa et al. (2017): DO international health partnerships contribute to reverse innovation? A mixed methods study of THET-supported partnerships in the UK. In: Globalization and Health, 13/2017.
- Lasker, Judith et al. (2018): Guidelines for responsible short-term global health activities: developing common principles. In: Globalization and Health, 14/2018.
- Macpherson, Laura; Colling, Maggie (2017): Training responsibly to improve global surgical and anaesthesia capacity through institutional health partnerships. A case study. In: Tropical Doctor, Vol. 47, 2017, p. 73–77.
- Miranda, Jaime et al. (2016): Towards sustainable partnerships in global health. The case of the CRONICAS Centre of Excellence in Chronic Diseases in Peru. In: Globalization and Health 12/2016.
- Mormina, Maru; Pinder, Sophie (2018): A conceptual framework for training of trainers (ToT) interventions in global health. In: Globalization and Health 14/2018.
- Raguin Gilles (2016): The ESTHER hospital partnership initiative – a powerful levy for building capacities to combat the HIV pandemic in low-resource countries. In: Globalization and Health, 1/2016.
- Shamsuzzoha, Syed (2013): Strengthening the evidence-policy interface for patient safety. Enhancing global health through hospital partnerships. In: Globalization and Health 9/2013.
- Vereinte Nationen (2019): Nachhaltige Entwicklung. Bericht 2019. New York: Vereinte Nationen – Hauptabteilung Wirtschaftliche und Soziale Angelegenheiten.
- Zocher, Ute et al. (2019): Participatory approach to quality development in infection prevention and control (IPC) in Nigerian health facilities. In: Infection Prevention in Practice 1 (July 2019), Healthcare Infection Society.

Other sources

Bundesministerium für Gesundheit (BMG 2020): PASQUALE – Partnership to improve patient safety and quality for care. Factsheet.

Bundesministerium für wirtschaftliche Zusammenarbeit (BMZ 2019c): BMZ-Portal, page „Partnerschaften zwischen Gesundheitseinrichtungen – ein Gewinn für alle Beteiligten“, <https://www.bmz.de/de/mitmachen/klinikpartnerschaften/index.html>, last access: May 31, 2020.

Bundesministerium für wirtschaftliche Zusammenarbeit, Else Kröner Fresenius Stiftung (BMZ/EKFS 2017c): Factsheet „Klinikpartnerschaften – Partner stärken Gesundheit“. BMZ/EKFS 2017.

CIA (2019): The World Factbook. See: <https://www.cia.gov/library/publications/the-world-factbook/> (last access: December 19, 2019).

Deutscher Akademischer Austausch-Dienst (DAAD 2019): Web Portal of the funding program ‚PAGEL – Partnerschaften für den Gesundheitssektor in Entwicklungsländern‘. See: <https://www.daad.de/de/infos-services-fuer-hochschulen/weiterfuehrende-infos-zu-daad-foerderprogrammen/pagel/> (last access, May 31, 2020)

European ESTHER Alliance (2020a): Web portal of the ESTHER Alliance for Global Health Partnerships, www.esther.eu (last access: May 31, 2020).

European ESTHER Alliance (2020b): ESTHER EFFECT Tool – Self Assessment Version. Retrieved under <https://esther.eu/wp-content/uploads/2018/04/FINAL-Esther-12PP-web.pdf> (last access: May 31, 2020)

National Academies of Sciences, Engineering, Medicine (NASEM 2018): Crossing the Global Quality Chasm, Improving Health Care Worldwide. Washington D.C.: NASEM.

World Health Organization (2011a): Patient safety in developing and transitional countries. New insights from Africa and the Eastern Mediterranean. Geneva: WHO

World Health Organization (2016a): Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level. Geneva: WHO.

World Health Organization (2017a): Patient safety. Making health care safer. Geneva: WHO.

World Health Organization (2019b): Web Portal of the African Partnership for Patient Safety. See: <https://www.who.int/patientsafety/implementation/apps/en/> (last access: December 19, 2019).

World Health Organization (2019c): Patient Safety Fact File. Geneva: WHO, September 2019.

World Health Organization (2020a): Portal of the WHO Regional Office for Africa, Page on Patient Safety, <https://www.afro.who.int/health-topics/patient-safety> (last access: June 1, 2020).

World Bank (2019): World Bank Open Data Portal, Free and open access to global development data, www.data.worldbank.org, (last access: December 18, 2019).

Annex 2: Links to additional questions from the Terms of Reference

The evaluation matrix and the report format of the central project evaluations follow a standard format based on OECD/DAC criteria. Additional questions were added to the Terms of Reference regarding (a) the BMZ commission, (b) IHP programme and (c) IHP partnership projects. Partly, they just operationalised existing standard evaluation questions and partly, they introduced additional aspects. However, these aspects, too, can be categorised under specific OECD/DAC criteria, or conclusions/recommendations.

Therefore, the report format was not altered, and additional questions from the ToR were integrated in the common CPE report structure. This annex summarises the text passages related to the additional questions:

Questions	Text passages
BMZ commission	
To what extent does the program integrate into BMZ priorities in the health sector (universal health coverage, health system strengthening)?	Coincides with Relevance/Dimension 1
To what extent does the instrument integrate into GIZ country (health) portfolio?	Area of Efficiency/Dimension 2
Balance of the collaboration with the Initiative Hospital Partnerships (GLOBE): lessons learned	Relevance/Dimension 4 (Adaptations), Effectiveness/Dimension 3 (Unintended results), Efficiency/Dimension 1 (Production efficiency), Factors of Success or Failure
Added value of HKP as a regional funding program with a regional and thematic focus and higher funding volume: options for its future development and possible scenarios	Relevance/Dimension 1 (Suitability), Factors of Success or Failure, Recommendations
Knowledge sharing: what are the benefits and costs for BMZ and GIZ from participating in the ESTHER Alliance?	Efficiency/Dimension 1 (Production efficiency)
Collaboration with BMBF: the case of the AMR network. Lessons learned for sustainability	Effectiveness/Dimension 2 (Contribution analysis, hypothesis 3), Factors of Success or Failure, Sustainability/Dimension 2 (Durability of results)
Synergy with other instruments of the German cooperation instruments: CIM experts	Efficiency/Dimension 2 (Production efficiency), Recommendation
University and hospital partnerships programme	
To what extent does HKP achieve its objectives?	Coincides with Effectiveness/Dimension 1 (goal-attainment)
Does HKP promote the right measures to achieve its goals?	Coincides with Relevance/Dimension 2 (Needs-orientation) and Dimension 3 (Adequacy of the design)
To what extent does the funding modality (3-year competitive rounds) contribute to sustainability of the achievements?	References to timespan in Effectiveness/Table 3), Sustainability/Dimension 2 (Durability of results), Factors of Success or Failure
What other positive and negative effects beyond the results matrix do hospital partnerships (HKP) generate (i.e. knowledge generation and spreading)?	Coincides with Effectiveness/Dimension 3 (Unintended results) and Impact /Dimension 3 (Unintended results)
Funding instrument (grants/ Zuschussverträge versus Leistungsverträge): benefits and disadvantages for HKP	The pertinence of grant contracts was not ques-

	tioned by any of the interviewees and the alternative does not seem to be a current issue. There is therefore no respective section in the evaluation report.
University and hospital partnership projects (Grants)	
To what extent do HKP partnership projects align to local needs/ to what extent do hospital partnerships meet the priorities of health systems in the partner countries?	Coincides with Relevance/Dimension 1 (Alignment) and Relevance/Dimension 2 (Needs-orientation)
Under what conditions are partnership projects more effective?	Coincides with Factors of Success and Failure
What effects does the funding provided by the Initiative have on the partnerships between two partners? Long-term sustainability: to what extent do changes prevail after the funding period finishes?	Sustainability
Do HKP projects have an impact in the Northern partners' institutions?	Effectiveness/Dimension 3
Do partnership projects spread the knowledge generated and influence strategies and policies in districts, regions and countries?	Coincides with Impact/Dimension 1
What other positive and negative effects beyond the results matrix do hospital partnerships (HKP) generate in the North and in the South, particularly in topics such as AMR or patient safety? How could these changes be followed-up in the future?	Coincides with Effectiveness/Dimension 3 (Unintended results) and Impact /Dimension 3 (Unintended results)

Annex 3: EVALUATION MATRIX

OECD-DAC Criterion RELEVANCE (max. 100 points)						
Assessment dimensions	Filter - Project Type	Evaluation questions	Evaluation indicators	Data collection methods (e.g. interviews, focus group discussions, documents, project/partner monitoring system, workshop, survey, etc.)	Data sources (list of relevant documents, interviews with specific stakeholder categories, specific monitoring data, specific workshop(s), etc.)	Evidence strength (moderate, good, strong)
The project concept (1) is in line with the relevant strategic reference frameworks. Max. 30 points	Standard	Which strategic reference frameworks exist for the project? (e.g. national strategies incl. national implementation strategy for 2030 agenda, regional and international strategies, sectoral, cross-sector change strategies, if bilateral project especially partner strategies, internal analysis frameworks e.g. safeguards and gender (2))	(1) The methodological approach is consistent with the strategic orientation of the GDC	Document analysis Semi-structures interviews with key informants	Offer Part A and B GDC strategy documents and guidelines (see Inception Report, Annex 1)	strong
	Standard	To what extent is the project concept in line with the relevant strategic reference frameworks?	(2) The methodological approach is consistent with the general principals and quality criteria of the European ESTHER Alliance		Documentation ESTHER Alliance principles (see Inception Report, Annex 1)	
	and Fragility	To what extent was the (conflict) context of the project adequately analysed and considered for the project concept (key documents: (Integrated) Peace and Conflict Assessment, Safeguard Conflict and Conflict Sensitivity documents)?	(3) The methodological approach is consistent with international standards and agreements, particularly by the World Health Organization (WHO)		WHO documents on patient safety and international health regulations (see Inception Report, Annex 1)	
	Standard	To what extent are the interactions (synergies/trade-offs) of the intervention with other sectors reflected in the project concept – also regarding the sustainability dimensions (ecological, economic, social)?	(4) with the strategic priorities of African partner countries in the health sector		Health Sector policies/strategies of the partner countries (to be retrieved during the evaluation phase)	
	Standard	To what extent is the project concept in line with the Development Cooperation (DC) programme (if applicable), the BMZ country strategy and BMZ sectoral concepts?			GDC representatives in Germany and partner countries (semi-structured interviews)	
	Standard	To what extent is the project concept in line with the (national) objectives of the 2030 agenda? To which Sustainable Development Goals (SDG) is the project supposed to contribute?				
The project concept (1) matches the needs of the target group(s). Max. 30 points	Standard	To what extent is the chosen project concept geared to the core problems and needs of the target group(s)?	(1) The core problem and the methodological approach are consistent with current sector analyses.	Document analysis Semi-structures interviews with key informants	Offer Part A and B Offers and Progress Reporting of Partnership Projects	strong
	Standard	How are the different perspectives, needs and concerns of women and men represented in the project concept?	(2) Extent to which perspectives of partner hospitals have been considered in the project plans.		Representatives of African partner institution (semi-structured interviews)	
	Standard	To what extent was the project concept designed to reach particularly disadvantaged groups (LNOB principle, as foreseen in the Agenda 2030)? How were identified risks and potentials for human rights and gender aspects included into the project concept?	(3) Target groups needs (e.g. LNOB, gender aspects) are addressed in the project plans.			
	Standard	To what extent are the intended impacts regarding the target group(s) realistic from today's perspective and the given resources (time, financial, partner capacities)?				
The project concept (1) is adequately designed to achieve the chosen project objective. Max. 20 points	Standard	Assessment of current results model and results hypotheses (theory of change, ToC) of actual project logic: - To what extent is the project objective realistic from today's perspective and the given resources (time, financial, partner capacities)? - To what extent are the activities, instruments and outputs adequately designed to achieve the project objective? - To what extent are the underlying results hypotheses of the project plausible? - To what extent is the chosen system boundary (sphere of responsibility) of the project (including partner) clearly defined and plausible? - Are potential influences of other donors/organisations outside of the project's sphere of responsibility adequately considered? - To what extent are the assumptions and risks for the project complete and plausible?	(1) Extent to which the results logic obeys to current quality criteria of GIZ (2) The potential effectiveness of partnership projects and TC interventions based on previous evidence and/or validated through the project monitoring (3) Key stakeholders of each intervention area confirm that TC interventions and partnership projects were strategically focused	Document analysis Semi-structures interviews with key informants	Offer Part A and B Offers and Progress Reporting of Partnership Projects Representatives of GDC in Germany and partner countries, Representatives of German and African partner institutions (semi-structured interviews)	strong
	Standard	To what extent does the strategic orientation of the project address potential changes in its framework conditions?				

	Standard	How is/was the complexity of the framework conditions and guidelines handled? How is/was any possible overloading dealt with and strategically focused?				
The project concept (1) was adapted to changes in line with requirements and re-adapted where applicable. Max. 20 points	Standard	What changes have occurred during project implementation? (e.g. local, national, international, sectoral, including state of the art of sectoral know-how)?	(1) involved universities and hospitals and other stakeholders confirm that the overall project concept has evolved according to requirements of the hospital partnerships (2) Involved universities and hospitals confirm that their respective project concepts have evolved according to requirements in the respective intervention areas.	Document analysis	Offer Part A and B	strong
	Standard	How were the changes dealt with regarding the project concept?		Semi-structures interviews with key informants	Progress Reporting of the TC module Offers and Progress Reporting of Partnership Projects All stakeholder groups, see overview in Inception Report (semi-structured interviews)	

(1) The 'project concept' encompasses project objective and theory of change (ToC, see 3) with activities, outputs, instruments and results hypotheses as well as the implementation strategy (e.g. methodological approach, CD-strategy, results hypotheses)

(2) In the GIZ Safeguards and Gender system risks are assessed before project start regarding following aspects: gender, conflict, human rights, environment and climate. For the topics gender and human rights not only risks but also potentials are assessed. Before introducing the new safeguard

(3) Theory of Change = GIZ results model = graphic illustration and narrative results hypotheses

(4) Deescalating factors/ connectors: e.g. peace-promoting actors and institutions, structural changes, peace-promoting norms and behavior. For more details on 'connectors' see: GIZ (2007): 'Peace and Conflict Assessment (PCA). Ein methodischer Rahmen zur konflikt- und friedensbezogenen Aus

(5) Escalating factors/ dividers: e.g. destructive institutions, structures, norms and behavior. For more details on 'dividers' see: GIZ (2007): 'Peace and Conflict Assessment (PCA). Ein methodischer Rahmen zur konflikt- und friedensbezogenen Ausrichtung von EZ-Maßnahmen', p. 135.

(6) All projects in fragile contexts, projects with FS1 or FS2 markers and all transitional aid projects have to weaken escalating factors/dividers and have to mitigate risks in the context of conflict, fragility and violence. Projects with FS1 or FS2 markers should also consider how to strengthen deescalat

OECD-DAC Criterion EFFECTIVENESS (max. 100 points)						
Assessment dimensions	Filter - Project Type	Evaluation questions	Evaluation indicators	Data collection methods (e.g. interviews, focus group discussions, documents, project/partner monitoring system, workshop, survey, etc.)	Data sources (list of relevant documents, interviews with specific stakeholder categories, specific monitoring data, specific workshop(s), etc.)	Evidence strength (moderate, good, strong)
<p>The project achieved the objective (outcome) on time in accordance with the project objective indicators.(1)</p> <p>Max. 40 points</p>	Standard	To what extent has the agreed project objective (outcome) been achieved (or will be achieved until end of project), measured against the objective indicators? Are additional indicators needed to reflect the project objective adequately?	Present degree of goal-attainment and anticipated degree of goal-attainment until the end of the project term for the following indicators:			
	and Fragility	For projects with FS1 or FS2 markers: 'To what extent was the project able to strengthen deescalating factors/ 'connectors'? '	Indicator M1: The share of partnerships between African and German health institutions funded by the project which implement a gender-sensitive solution for an identified patient treatment deficit has risen from 0 % to 80 %	Document analysis Semi-structured interviews	Progress reporting of the TC-module Progress reporting of the partnership projects Representatives of German and African partner institutions (semi-structured interviews)	strong
	Standard	To what extent is it foreseeable that unachieved aspects of the project objective will be achieved during the current project term?	Indicator M2: The share of partnerships between African and German health institutions funded by the project which implement a specific training offer based on identified and analysed treatment deficits has risen from 0 % to 80 %	Document analysis Semi-structured interviews	Progress reporting of the TC-module Progress reporting of the partnership projects Representatives of German and African partner institutions (semi-structured interviews)	strong
			Indicator M3: The number of technical/scientific articles produced by the funded partnerships and related to patient safety that have been discussed in international networks has risen from 0 to 10.	Document analysis	Technical articles published by funded partnerships (to be retrieved during the evaluation phase)	strong
			Partnership Project Outcomes 1: Extent to which laboratory and hygiene capacities of partner institutions have improved	Document analysis Semi-structured interviews	Progress reporting of the partnership projects Representatives of German and African partner institutions (semi-structured interviews)'	good
<p>The activities and outputs of the project contributed substantially to the project objective achievement (outcome).(1)</p> <p>Max. 30 points</p>	Standard	To what extent have the agreed project outputs been achieved (or will be achieved until the end of the project), measured against the output indicators? Are additional indicators needed to reflect the outputs adequately?	Results Hypotheses to be assessed:			
	Standard	How does the project contribute via activities, instruments and outputs to the achievement of the project objective (outcome)? (contribution-analysis approach)	(1) The combination of providing financial grants and planning assistance (A-1) has led to the implementation of solutions for identified deficits in patient treatment and care (MI-1) and the related implementation of training offers (MI-2) to be analysed against a counterfactual scenario without GIZ funding (applies only for those partnership that already existed prior to the measure).	Document analysis Semi-structured interviews	Offer, Results Model Progress reporting of the partnership projects Representatives of GDC in partner countries and of German and African partner institutions (semi-structured interviews)	good
	Standard	Implementation strategy: Which factors in the implementation contribute successfully to or hinder the achievement of the project objective? (e.g. external factors, managerial setup of project and company, cooperation management)	(2) Solutions (MI-1) and capacity development measures (MI-2) implemented by the partnerships (see the individual project plans) have improved the conditions for the patient safety in the target facilities (regarding laboratory and hygiene capacities/O-1, quality management/O-2, quality of treatment and care/O-3, or other outcome categories as specified in the project plans).	Document analysis Semi-structured interviews	Offer, Results Model Progress reporting of the partnership projects Representatives of GDC in partner countries and of German and African partner institutions (semi-structured interviews)	good
	Standard	What other/alternative factors contributed to the fact that the project objective was achieved or not achieved?	(3) The exchange of experiences (B-4) and technical contributions (MI-3) combined with the TC support towards the coordination with relevant stakeholders (e.g. development partners, private sector, C-4) has contributed to better linkages of the IHPs with other European and/or multilateral actors in the	Document analysis Semi-structured interviews	Offer, Results Model Progress reporting of the partnership projects Representatives of GDC in partner countries and of German and African partner institutions (semi-structured interviews)	strong
	Standard	What would have happened without the project?				
<p>No project-related (unintended) negative results have occurred – and if any negative results occurred the project responded</p>	Standard	Which (unintended) negative or (formally not agreed) positive results does the project produce at output and outcome level and why?	The project and the funding partners periodically monitor framework conditions, risks and unintended effects based on de-fined processes/tools/instruments	Document analysis Semi-structured interviews	Offer, Results Model Progress reporting of the partnership projects Representatives of GDC in partner countries and of German and African partner institutions (semi-	strong

adequately.	Standard	How were risks and assumptions (see also GIZ Safeguards and Gender system) as well as (unintended) negative results at the output and outcome level assessed in the monitoring system (e.g. 'Kompass')? Were risks already known during the concept phase?	The rationale of management decisions based on the identification of external changes/risks and/or unintended results is documented and conducive towards the project goal	Document analysis Semi-structured interviews	Offer, Results Model Progress reporting of the partnership projects Representatives of GDC in partner countries and of German and African partner institutions (semi-Offer, Results Model)	strong
The occurrence of additional (not formally agreed) positive results has been monitored and additional opportunities for further positive results have been seized.	Standard	What measures have been taken by the project to counteract the risks and (if applicable) occurred negative results? To what extent were these measures adequate?	No project-related negative results have occurred – and if any negative results occurred the project responded adequately	Document analysis Semi-structured interviews	Offer, Results Model Progress reporting of the partnership projects Representatives of GDC in partner countries and of German and African partner institutions (semi-	good
Max. 30 points	Standard	To what extent were potential (not formally agreed) positive results at outcome level monitored and exploited?				

(1) The first and the second evaluation dimensions are interrelated: if the contribution of the project to the objective achievement is low (2nd evaluation dimension) this must be considered for the assessment of the first evaluation dimension also.

(2) Risks in the context of conflict, fragility and violence: e.g. contextual (e.g. political instability, violence, economic crises, migration/refugee flows, drought, etc.), institutional (e.g. weak partner capacity, fiduciary risks, corruption, staff turnover, investment risks) and personnel (murder, robbery, kidnapping, medical etc.). For more details see GIZ (2014): 'Context- and conflict-sensitive results-based monitoring system (RRM) Supplement to: The 'Guidelines on designing and using a results-based monitoring system (RRM) system' on 27 and 28

Annex 1: EVALUATION MATRIX

OECD-DAC Criterion IMPACT (max. 100 points)						
Assessment dimensions	Filter - Project Type	Evaluation questions	Evaluation indicators	Data collection methods (e.g. interviews, focus group discussions, documents, project/partner monitoring system, workshop, survey, etc.)	Data sources (list of relevant documents, interviews with specific stakeholder categories, specific monitoring data, specific workshop(s), etc.)	Evidence strength (moderate, good, strong)
The intended overarching development results have occurred or are foreseen (plausible reasons). (1) Max. 40 points	Standard	To which overarching development results is the project supposed to contribute (cf. module and programme proposal with indicators/ identifiers if applicable, national strategy for implementing 2030 Agenda, SDGs)? Which of these intended results at the impact level can be observed or are plausible to be achieved in the future?	Identification of potentials for impact in the following categories:			
	Standard	Indirect target group and 'Leave No One Behind' (LNOB): Is there evidence of results achieved at indirect target group level/specific groups of population? To what extent have targeted marginalised groups (such as women, children, young people, elderly, people with disabilities, indigenous peoples, refugees, IDPs and migrants, people living with HIV/AIDS, the poorest of the poor) been reached?	(1) The trust of patients in treatment safety of African partner clinics is strengthened	Semi-structured interviews	Representatives of African partner institutions	moderate
			(2) The trust of patients in the health system in the partner countries is strengthened	Semi-structured interviews	Representatives of African partner institutions	moderate
			(3) Patients seek treatment in a more timely manner	Semi-structured interviews, Secondary data analysis	Representatives of African partner institutions Hospital data	moderate
The project objective (outcome) of the project contributed to the occurred or foreseen overarching development results (impact).(1) Max. 30 points	Standard	To what extent is it plausible that the results of the project on outcome level (project objective) contributed or will contribute to the overarching results? (contribution-analysis approach)	Results Hypotheses to be assessed:			
	Standard	What are the alternative explanations/factors for the overarching development results observed? (e.g. the activities of other stakeholders, other policies)	(1) Better linkages of International Health Partnerships with other European and/or multilateral actors in the health sector (C-6), improved learning of the partnerships from project experiences (B-4) and exchange of experiences between partners (O-4) enable the partnerships to better access cofinancing or other support by international development partners (I-4).	Document analysis Semi-structured interviews	Offer, Results Model Progress reporting of the TC module Progress reporting of the partnership project Representatives of German and African partner institutions (semi-structured interviews)	strong
	Standard	To what extent is the impact of the project positively or negatively influenced by framework conditions, other policy areas, strategies or interests (German ministries, bilateral and multilateral development partners)? How did the project react to this?				
	Standard	What would have happened without the project?				
	Standard	To what extent has the project made an active and systematic contribution to widespread impact and were scaling-up mechanisms applied (2)? If not, could there have been potential? Why was the potential not exploited? To what extent has the project made an innovative contribution (or a contribution to innovation)? Which innovations have been tested in different regional contexts? How are the innovations evaluated by which partners?				
No project-related (unintended) negative results at impact level have occurred – and if any negative results occurred the project responded adequately The occurrence of additional (not formally agreed) positive results at impact level has been monitored and additional opportunities for further positive results have been seized. Max. 30 points	Standard	Which (unintended) negative or (formally not agreed) positive results at impact level can be observed? Are there negative trade-offs between the ecological, economic and social dimensions (according to the three dimensions of sustainability in the Agenda 2030)? Were positive synergies between the three dimensions exploited?	The project and the funding partners periodically monitor framework conditions risks and unintended effects based on defined process-es/tools/instruments	Document analysis Semi-structured interviews	Offer, Results Model Progress reporting of the partnership project Representatives of GDC in partner countries and of German and African partner institutions (semi-structured interviews)	good
	Standard	To what extent were risks of (unintended) results at the impact level assessed in the monitoring system (e.g. 'Kompass')? Were risks already known during the planning phase?	The rationale of management decisions based on the identification of external changes/risks and/or unintended results documented and conducive towards the	Document analysis Semi-structured interviews	Offer, Results Model Progress reporting of the partnership project Representatives of GDC in partner countries and of German and African partner	good
	Standard	What measures have been taken by the project to avoid and counteract the risks/negative results/trade-offs (3)?	No project-related negative results have occurred – and if any negative results occurred the project responded adequately	Document analysis Semi-structured interviews	Offer, Results Model Progress reporting of the partnership project Representatives of GDC in partner countries and of German and African partner	strong
	Standard	To what extent have the framework conditions played a role in regard to the negative results? How did the project react to this?				
	Standard	To what extent were potential (not formally agreed) positive results and potential synergies between the ecological, economic and social dimensions monitored and exploited?				

Annex 1: EVALUATION MATRIX

OECD-DAC Criterion EFFICIENCY (max. 100 points)						
Assessment dimensions	Filter - Project Type	Evaluation questions	Evaluation indicators (pilot phase for indicators - only available in German so far)	Data collection methods (e.g. interviews, focus group discussions, documents, project/partner monitoring system, workshop, survey, etc.)	Data sources (list of relevant documents, interviews with specific stakeholder categories, specific monitoring data, specific workshop(s), etc.)	Evidence strength (moderate, good, strong)
The project's use of resources is appropriate with regard to the outputs achieved. [Production efficiency: Resources/Outputs] Max. 70 points	Standard	To what extent are there deviations between the identified costs and the projected costs? What are the reasons for	Das Vorhaben steuert seine Ressourcen gemäß des geplanten Kostenplans (Kostenzeilen). Nur bei nachvollziehbarer Begründung erfolgen Abweichungen vom Kostenplan.	Cost analysis, further document analysis and semi-structured interviews Follow-the -money approach	Project offer, Costing-plan, Cost-Obligo-Data, Efficiency Tool, Operational Plans and Progress Reports of the TC-module	strong
	Standard	Focus: To what extent could the outputs have been maximised with the same amount of resources and under the same framework conditions and with the same or better quality (maximum principle)? (methodological minimum standard: Follow-the-money approach)	Das Vorhaben reflektiert, ob die vereinbarten Wirkungen mit den vorhandenen Mitteln erreicht werden können.	Document analysis Semi-structured interviews	Operational Plans and Progress Reports of the TC-module	strong
	Standard		Das Vorhaben steuert seine Ressourcen gemäß der geplanten Kosten für die vereinbarten Leistungen (Outputs). Nur bei nachvollziehbarer Begründung erfolgen Abweichungen von den Kosten. Die übergreifenden Kosten des Vorhabens stehen in einem angemessenen Verhältnis zu den Kosten für Outputs. Die durch ZAS Aufschriebe erbrachten Leistungen haben einen nachvollziehbaren Mehrwert für die Erreichung der Outputs des Vorhabens.	Cost analysis, further document analysis and semi-structured interviews Follow-the -money approach	Project offer, Costing-plan, Cost-Obligo-Data, Efficiency Tool, Operational Plans and Progress Reports of the TC-module Project personnel (semi-structured)	strong
	Standard		Die übergreifenden Kosten des Vorhabens stehen in einem angemessenen Verhältnis zu den Kosten der Outputs.	Document analysis Semi-structured interviews	Project offer, Efficiency Tool Progress Reports of the TC-module Project personnel (semi-structured)	moderate
	Standard		Die durch ZAS Aufschriebe erbrachten Leistungen haben einen nachvollziehbaren Mehrwert für die Erreichung der Outputs des Vorhabens.	Document analysis Semi-structured interviews	Cost-Obligo-Data, Efficiency Tool, Progress Reports of the TC-module Project personnel (semi-structured)	good
	Standard	Focus: To what extent could outputs have been maximised by reallocating resources between the outputs? (methodological	Das Vorhaben steuert seine Ressourcen, um andere Outputs schneller/ besser zu erreichen, wenn Outputs erreicht wurden bzw. diese nicht erreicht werden können (Schlussevaluierung).	Cost analysis, further document analysis and semi-structured interviews Follow-the -money approach	Project offer, Costing-plan, Cost-Obligo-Data, Efficiency Tool, Operational Plans and Progress Reports of the TC-module	strong
	Standard	Were the output/resource ratio and alternatives carefully considered during the design and implementation process – and so, how? (methodological minimum standard: Follow-the-money approach)	Das im Modulvorschlag vorgeschlagene Instrumentenkonzept konnte hinsichtlich der veranschlagten Kosten in Bezug auf die angestrebten Outputs des Vorhabens gut realisiert werden.	Document analysis Semi-structured interviews	Project offer, Costing-plan, Cost-Obligo-Data, Efficiency Tool, Instrument Concept, Progress Reports of the TC module	strong
	Standard		Die im Modulvorschlag vorgeschlagene Partnerkonstellation und die damit verbundenen Interventionsebenen konnte hinsichtlich der veranschlagten Kosten in Bezug auf die angestrebten Outputs des Vorhabens gut realisiert werden.	Document analysis Semi-structured interviews	Project offer, Costing-plan, Cost-Obligo-Data, Efficiency Tool, Progress Reports of the TC module	strong
	Standard		Der im Modulvorschlag vorgeschlagene thematische Zuschnitte für das Vorhaben konnte hinsichtlich der veranschlagten Kosten in Bezug auf die angestrebten Outputs des Vorhabens gut realisiert werden.	Document analysis Semi-structured interviews	Project offer, Costing-plan, Cost-Obligo-Data, Efficiency Tool, Operational plans Progress Reports of the TC module	strong
	Standard		Die im Modulvorschlag beschriebenen Risiken sind hinsichtlich der veranschlagten Kosten in Bezug auf die angestrebten Outputs des Vorhabens gut nachvollziehbar.	Document analysis Semi-structured interviews	Project offer, Costing-plan, Cost-Obligo-Data, Efficiency Tool, Progress Reports of the TC module	good
	Standard		Die im Modulvorschlag beschriebene Reichweite des Vorhabens (z.B. Regionen) konnte hinsichtlich der veranschlagten Kosten in Bezug auf die angestrebten Outputs des Vorhabens voll realisiert werden.	Document analysis Semi-structured interviews	Project offer, Costing-plan, Cost-Obligo-Data, Efficiency Tool, Operational plans Progress Reports of the TC module	strong
	Standard		Der im Modulvorschlag beschriebene Ansatz des Vorhabens hinsichtlich der zu erbringenden Outputs entspricht unter den gegebenen Rahmenbedingungen dem state-of-the-art.	Document analysis Semi-structured interviews	Project offer, Offers of the funding projects WHO documents on patient safety and international health regulations Progress Reports of the TC and of the	good
	Standard	For interim evaluations based on the analysis to date: To what extent are further	(-)	(-)	(-)	
The project's use of resources is appropriate with regard to achieving the projects objective (outcome). [Allocation efficiency:	Standard	To what extent could the outcome (project objective) have been maximised with the	Das Vorhaben orientiert sich an internen oder externen Vergleichsgrößen, um seine Wirkungen kosteneffizient zu erreichen.	Semi-structured interviews	Project personnel (semi-structured interviews)	strong
	Standard	Were the outcome-resources ratio and alternatives carefully considered during the conception and implementation process – and if so, how? Were any scaling-up	Das Vorhaben steuert seine Ressourcen zwischen den Outputs, so dass die maximalen Wirkungen im Sinne des Modulziels erreicht werden. (Schlussevaluierung)	Document analysis Semi-structured interviews	Project offer, Costing-plan, Cost-Obligo-Data, Efficiency Tool, Operational plans Progress Reports of the TC module	moderate

Resources/Outcome]	Max. 30 points	Standard	options considered?	Das im Modulvorschlag vorgeschlagene Instrumentenkonzept konnte hinsichtlich der veranschlagte Kosten in Bezug auf das angestrebte Modulziel des Vorhabens gut realisiert werden. Comment: As mentioned in previous CPEs, I don't understand how to separate this indicator from its "sibling" under Production Efficiency. What is the "realization of the instrument concept in regard to the outputs" compared to the "realization of the instrument concept in regards to the outcome/the module objective"? I've posed this question earlier and so far, there has been no clarification. From my point of view, Allocation efficiency is predominantly a question of how to allocate resources among outputs in order to achieve the maximum outcome (see indicator above); Once defined, the instrument concept and the further indicators are production oriented, i.e. I can apply instruments to produce the best possible output (production efficiency), and I can chose outputs which contribute in the best possible way to the outcome (allocation efficiency) BUT the instruments themselves do produce output, NOT outcome. That's way I don't understand the reason for duplicating this and the subsequent indicators in the outcome section.	(-)	(-)	(-)
		Standard		Die im Modulvorschlag vorgeschlagene Partnerkonstellation und die damit verbundenen Interventionsebenen konnte hinsichtlich der veranschlagten Kosten in Bezug auf das angestrebte Modulziel des Vorhabens gut realisiert werden. See comment above	(-)	(-)	(-)
		Standard		Der im Modulvorschlag vorgeschlagene thematische Zuschnitte für das Vorhaben konnte hinsichtlich der veranschlagten Kosten in Bezug auf das angestrebte Modulziel des Vorhabens gut realisiert werden. See comment above	(-)	(-)	(-)
		Standard		Die im Modulvorschlag beschriebenen Risiken sind hinsichtlich der veranschlagten Kosten in Bezug auf das angestrebte Modulziel des Vorhabens gut nachvollziehbar. See comment above	(-)	(-)	(-)
		Standard		Die im Modulvorschlag beschriebene Reichweite des Vorhabens (z.B. Regionen) konnte hinsichtlich der veranschlagten Kosten in Bezug auf das angestrebte Modulziel des Vorhabens voll realisiert werden. See comment above	(-)	(-)	(-)
		Standard		Der im Modulvorschlag beschriebene Ansatz des Vorhabens hinsichtlich des zu erbringenden Modulziels entspricht unter den gegebenen Rahmenbedingungen dem state-of-the-art.	Document analysis Semis-structured interviews	Project offer, Offers of the funding projects WHO documents on patient safety and international health regulations Progress Reports of the TC and of the	good
		Standard	To what extent were more results achieved through cooperation / synergies and/or leverage of more resources, with the help of other ministries, bilateral and multilateral donors and organisations (e.g. co-financing and/or other GIZ projects)? If so, was the relationship between costs and results appropriate or did it even improve efficiency?	Das Vorhaben unternimmt die notwendigen Schritte, um Synergien mit Interventionen anderer Geber auf der Wirkungsebene vollständig zu realisieren.	Document analysis Semis-structured interviews	Project offer, Offers of the funding projects Progress Reports of the TC and of the funding projects Project personnel (semi-structured interviews)	strong
		Standard		Wirtschaftlichkeitsverluste durch unzureichende Koordinierung und Komplementarität zu Interventionen anderer Geber werden ausreichend vermieden.	Document analysis Semis-structured interviews	Project offer, Offers of the funding projects Progress Reports of the TC and of the funding projects Project personnel (semi-structured interviews)	good
		Standard		Das Vorhaben unternimmt die notwendigen Schritte, um Synergien innerhalb der deutschen EZ vollständig zu realisieren.	Document analysis Semis-structured interviews	Project offer, Offers of the funding projects Progress Reports of the TC and of the funding projects Project personnel (semi-structured interviews)	strong
		Standard		Wirtschaftlichkeitsverluste durch unzureichende Koordinierung und Komplementarität innerhalb der deutschen EZ werden ausreichend vermieden.	Document analysis Semis-structured interviews	Project offer, Offers of the funding projects Progress Reports of the TC and of the funding projects Project personnel (semi-structured interviews)	good
		Standard		Die Kombifinanzierung hat zu einer signifikanten Ausweitung der Wirkungen geführt bzw. diese ist zu erwarten.	(-)	(-)	(-)

Standard	Durch die Kombifinanzierung sind die übergreifenden Kosten im Verhältnis zu den Gesamtkosten überproportional gestiegen.	(-)	(-)	(-)
Standard	Die Partnerbeiträge stehen in einem angemessenen Verhältnis zu den Kosten für die Outputs des Vorhabens.	Document analysis Semis-structured interviews	Project offer, Offers of the funding projects Progress Reports of the TC and of the funding projects Project personnel (semi-structured)	moderate

OECD-DAC Criterion SUSTAINABILITY (max. 100 points)						
Assessment dimensions	Filter - Project Type	Evaluation questions	Evaluation indicators	Data collection methods (e.g. interviews, focus group discussions, documents, project/partner monitoring system, workshop, survey, etc.)	Data sources (list of relevant documents, interviews with specific stakeholder categories, specific monitoring data, specific workshop(s), etc.)	Evidence strength (moderate, good, strong)
Prerequisite for ensuring the long-term success of the project: Results are anchored in (partner) structures. Max. 50 points	Standard	What has the project done to ensure that the results can be sustained in the medium to long term by the partners themselves?	Indicators for the assessment dimension (do not coincide line by line with the evaluation questions): (1) Individual and organizational and institutional capacities of the African funding partners in patient safety related areas are consolidated	Document analysis Semis-structured interviews	Progress reporting of the partnership projects Representatives of German and African partner institutions (semi-structured interviews)	good
	Standard	In what way are advisory contents, approaches, methods or concepts of the project anchored/institutionalised in the (partner) system?	(2) Extent to which funding project results have been formally integrated in partner structures/processes/strategies etc.	Document analysis Semis-structured interviews	Progress reporting of the partnership projects Representatives of German and African partner institutions (semi-structured interviews)	good
	Standard	To what extent are the results continuously used and/or further developed by the target group and/or implementing partners?	(3) Extent to which partnerships have been strengthened beyond the funding project (e.g. thematic scope, continuity, mid-term planning)	Document analysis Semis-structured interviews	Progress reporting of the partnership projects Representatives of German and African partner institutions (semi-structured interviews)	good
	Standard	To what extent are resources and capacities at the individual, organisational or societal/political level in the partner country available (long-term) to ensure the continuation of the results achieved?	(4) Extent to which German partner institutions remain active in development cooperation related areas	Document analysis Semis-structured interviews	Progress reporting of the partnership projects Representatives of German partner institutions (semi-structured interviews)	good
	Standard	If no follow-on measure exists: What is the project's exit strategy? How are lessons learnt for partners and GIZ prepared and documented?				
	and Fragility	To what extent was the project able to ensure that escalating factors/dividers (1) in the context of conflict, fragility and violence have not been strengthened (indirectly) by the project in the long term? To what extent was the project able to strengthen deescalating factors/connectors (2) in a sustainable way?				
Forecast of durability: Results of the project are permanent, stable and long-term resilient. Max. 50 points	Standard	To what extent are the results of the project durable, stable and resilient in the long-term under the current circumstances?	<i>The core criteria for the sustainability evaluation are assumption-based instead of measurement based. Therefore, we recommend abstaining from formulating indicators (which are associated with actual measurement) and rely on the guiding questions only.</i>	Semi-structured interviews	All stakeholders (see overview in Inception Report)	moderate
	Standard	What risks and potentials are emerging for the durability of the results and how likely are these factors to occur? What has the project done to reduce these risks?				

(1) Escalating factors/ dividers: e.g. destructive institutions, structures, norms and behavior. For more details on 'dividers' see: GIZ (2007): 'Peace and Conflict Assessment (PCA). Ein methodischer Rahmen zur konflikt- und friedensbezogenen Ausrichtung von EZ-Maßnahmen', p. 135.

(2) Deescalating factors/ connectors: e.g. peace-promoting actors and institutions, structural changes, peace-promoting norms and behavior. For more details on 'connectors' see: GIZ (2007): 'Peace and Conflict Assessment (PCA). Ein methodischer Rahmen zur konflikt- und friedensbezogenen Ausrichtung von EZ-Maßnahmen', p. 135.

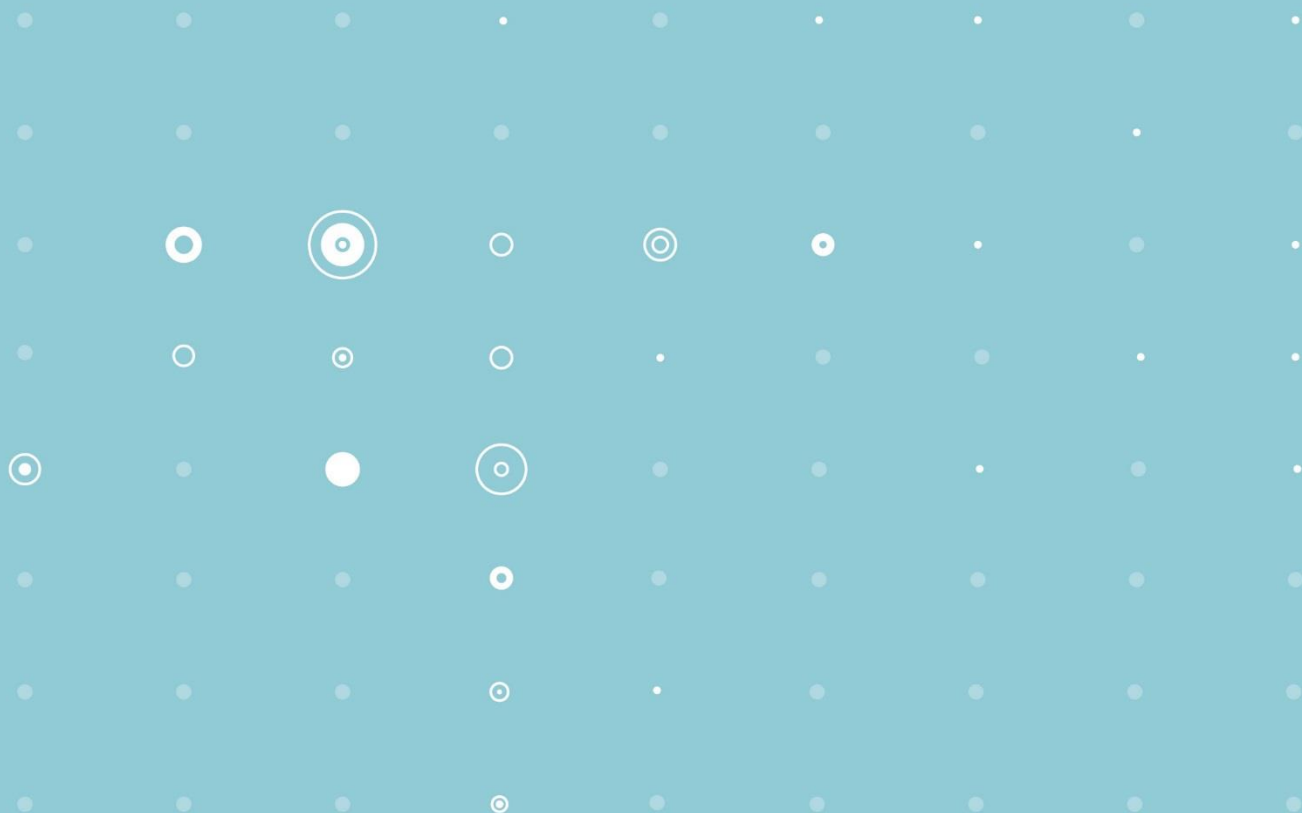


Photo credits and sources

Photo credits/sources:

© GIZ / Ranak Martin, Carlos Alba, Dirk Ostermeier, Ala Kheir

Disclaimer:

This publication contains links to external websites. Responsibility for the content of the listed external sites always lies with their respective publishers. When the links to these sites were first posted, GIZ checked the third-party content to establish whether it could give rise to civil or criminal liability. However, the constant review of the links to external sites cannot reasonably be expected without concrete indication of a violation of rights. If GIZ itself becomes aware or is notified by a third party that an external site it has provided a link to gives rise to civil or criminal liability, it will remove the link to this site immediately. GIZ expressly dissociates itself from such content.

Maps:

The maps printed here are intended only for information purposes and in no way constitute recognition under international law of boundaries and territories. GIZ accepts no responsibility for these maps being entirely up to date, correct or complete. All liability for any damage, direct or indirect, resulting from their use is excluded.

Photo credits and sources



Deutsche Gesellschaft für
Internationale Zusammenarbeit (GIZ) GmbH

Registered offices
Bonn und Eschborn

Friedrich-Ebert-Allee 36 + 40
53113 Bonn, Germany
T +49 228 44 60-0
F +49 228 44 60-17 66

Dag-Hammarskjöld-Weg 1-5
65760 Eschborn, Germany
T +49 61 96 79-0
F +49 61 96 79-11 15

E info@giz.de
I www.giz.de