

Central project evaluation – executive summary

ESTHER university and hospital partnerships in Africa

Title	ESTHER University and hospital partnerships in Africa		
Country / Region / Global	Africa		
Sector und CRS Code	12181 (70%), 12191 (30%)		
Project number	2016.2035.0		
Commissioning party	German Federal Ministry for Economic Cooperation and Development (BMZ)		
Lead executing agency / implementation partner	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH		
Project value	EUR 4,000,000		
Project term	1 June 2016 to 30 November 2019		
Reporting year	2020	Sample year	2017

Context of the project

Sub-Saharan Africa is one of the poorest regions in the world. According to the 2018 Human Development Index, 31 of the 37 countries categorised as having 'low human development' are in 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.

Life expectancy at birth is as low as 57 years in West Africa and 64 years in East Africa, compared to the global average of over 72 years. Average health expenditure per capita in sub-Saharan Africa is USD 78.37 compared to a global average of USD 1,026.40 (2016). Worldwide, on average there are approximately 15 physicians available per 10,000 people; in sub-Saharan Africa there are only 2 (2015). 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 large numbers of the population avoiding public health services and ignoring instructions from health workers, thus delaying diagnosis and treatment and accelerating epidemic outbreaks.

Health detriments due to inadequate treatment are widespread and contribute to general distrust in public health services. Sound data on malpractice 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. While patient safety is a minimum precondition for the effectiveness and increased use of health services, African states with weak health systems do not have the capacity of ensuring a sufficient level of patient safety (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 enhancing patient safety, (d) weak knowledge management and peer learning culture in both South–South and North–South cooperation and (e) lack of resources in general and of linkages with potential funding partners and programmes in particular.

Brief description of the project

Germany joined the ESTHER Alliance for Global Health Partnerships 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 was the ESTHER Alliance University and Hospital Partnerships in Africa technical cooperation (TC) measure. The project was carried out by GIZ on behalf of BMZ. It had a duration of 3 years 6 months from June 2016 to November 2019 and an overall budget of EUR 4,000,000. It was originally designed as a stand-alone project until, in 2017, 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 conceptual 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 did not specify changes in the partner countries but instead overarching result categories and the number of projects that contributed 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 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 and the partnerships operated independently on the basis of financial resources provided by BMZ and administered by GIZ. Complementary technical assistance covered the selection process for funded partnership projects, methodological advice during the planning process, support for

peer-learning processes and networking with external stakeholders. Overall, the project consisted in 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: Creating 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: Creating linkages with stakeholders and supporting partners of institutional health partnerships.** Objective: Stakeholders and supporting partners of institutional health partnerships for 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. The final beneficiaries were the patients of African health institutions. 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 their national health systems, the full extent of target groups that potentially benefited is not quantifiable.



Project objective / areas of intervention

Assessment according to DAC criteria

Relevance

The current BMZ position paper on global health includes 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 sets a specific target for realisation of hospital partnerships and led to the creation of the BMZ Hospital Partnerships – Partners Strengthen Health initiative in 2016. Conceptually, the project is in line with both the WHO approach on twinning partnerships and the European ESTHER Alliance Charter, which include principles such as reciprocity, focus on capacity building for Southern partners, and alignment with the health system priorities of the partner countries.

Against the background of particularly pronounced patient safety challenges in the African region, the selection of the funding topic was pertinent to reducing severe, including life-threatening, risks for patients. While the selection criteria for funding ensured funding of systemically relevant African health institutions (e.g. referral or teaching hospitals), the specific needs of the African institutions were adequately considered, not only their involvement in the planning stage for the project proposals but also through further situational analysis at the initial stage of the implementation processes.

About 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 either in the project designs or in reporting.

While the results logic of the overall project was generally plausible, the goal-system levels (outputs, project or outcome objectives) were interpreted in different ways by the individual partnership projects, thus complicating the comparability of reported outputs and outcomes. Substantially, however, the projects designs were convincing, characterised by a clear focus on specific patient-safety-related clinical issues and mainly realistic targets.

Effectiveness

The partnership projects implemented a wide range of solutions for specific patient-safety areas, e.g. in the areas of hygiene and prevention of nosocomial infections, management of antimicrobial resistance (AMR) and antibiotic stewardship (ABS), improved laboratory services, infection prevention and control (IPC), patient safety in emergency care, among others (project objective indicator 1).

All 15 partnerships implemented training measures on their project topics, which comprised both theoretical and practical hands-on training for clinical staff, blended-learning modalities, online courses, self-learning platforms, coaching and mentoring, among others.

Overall, output and project objectives were attained to a reasonable extent. Both at output and project objective/outcome level, 11 of the 15 partnerships mostly or completely achieved the intended outputs; goal attainment was seriously hampered in only 2 cases. Whereas achievements at output level were well-documented, outcome-level results were mostly reported in a descriptive/qualitative manner, with five partnerships providing quantitative evidence. The contribution analysis confirmed that comparably meaningful interventions on patient safety could not have been carried out without the funding provided. Furthermore, coordination between partnerships (including regional cooperation between African partners) was emphasised, leading for example to the creation of the thematic AMR network, which was consolidated beyond the remit of the evaluated project.

Research activities on clinical topics related to the project objectives were an integral part of the university hospital partnerships and were reported for 12 of the 15 funding projects. At the time of the evaluation, four partnerships had published a total of eight articles, with a further three articles in the process of publication. Apart from these articles, 33 (mostly oral or poster) presentations on research results and/or project experience were given at international conferences or network meetings by the end of the project in November 2019.

Implemented solutions for patients safety	95%
Capacity development	100%
Published and presented experiences	100%

Achievement of project objective indicators

Impact

It could plausibly be assumed that attainment of the project objectives closely correlated with direct health-related benefits for patients, even though in most cases no further evidence for health-related indicators was available.

The systemic relevance of the African partner institutions was a selection criterion for funding. Though most partnerships focused mainly on the bilateral or trilateral cooperation of the health institutions involved, processes and potentials related to spill-over of skills and knowledge to further facilities were documented by more than two thirds of the partnerships. 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 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. However, the potential of these partnerships to contribute to the coronavirus response could only be deduced from the successful implementation of their respective measures, since there was no additional evidence for further assessment.

Efficiency

To ensure the results orientation of the funded projects, limits or threshold values for the maximum shares for staff costs and for operational research and the minimum share for capacity development were set for the project proposals. The funding projects leveraged significant in-kind inputs from German and African partners, which were not quantifiable by the evaluation but were essential for the 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. Analysing the costs against the results achieved (see effectiveness and impact), a reasonable output/resource ratio was achieved.

A key factor for allocation efficiency was the extent to which synergies within the German development cooperation were pursued. Potential interconnections with bilateral or regional TC projects in the health sector were enquired in the application templates and applied as an assessment criterion for project selection. Even so, the partnerships did not hold particularly high expectations, retaining their legitimacy as stand-alone projects while at the same time ensuring 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.

At partnership level, few interconnections with other development partners were reported, which is to be expected given the narrowly focused clinical intervention areas of most partnerships. At the overall level, however, the project constantly networked with other stakeholders, such as the German Academic Exchange Service (DAAD), the German Federal Ministry for Education and Research (BMBF), and the private sector (e.g. Bayer AG). Among others, cofinancing from BMBF for the research activities of the AMR network and a spin-off project on AMR with the private sector (Bayer AG) were achieved.

Since the university hospitals involved already had their own excellent cooperation networks and funding relationships, the evaluation results were not conclusive in regard to the extent to which existing ties were systematically strengthened beyond specific funding opportunities facilitated by the project.

Sustainability

Due to the focus on specific clinical improvements, absorption of specific procedural or clinical changes by the African partner hospitals were expected, rather than complex organisational change. The most common mechanisms used were (a) elaboration of standard operating procedures, (b) integration of training content in the curricula of training institutions involved, (c) training of trainers or mentors, (d) local production of consumables (particularly disinfectants) for hygiene measures and (e) establishment of self-learning or peer-learning mechanisms in the African partner hospitals. Project reports mostly did not elaborate on the extent of consolidation of these mechanisms; some explicitly highlighted the African partners' needs for further external support for consolidation.

More cross-cutting management-related interventions (e.g. leadership training, establishment of quality circles) were also reported but were clearly more challenging, given the limitations of interventions based on intermittent peer visits. Successes (e.g. enhancement of IPC teams and focal person structures in 14 hospitals trained by the Robert Koch Institute and the Nigeria Centre for Disease Control) were observed, as were failures.

Generally, the expected durability of results was assessed rather critically. Even some projects with high goal-attainment highlighted the need for further consolidation of results and continued support to their African partners. On the other hand, most interventions were well-adapted to low-resource settings, which meant that (a) identified solutions 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, use of locally available equipment).

Most partnerships functioned with a long-term perspective but still needed a stable flow of consecutive funding for meaningful implementation activities. 7 of the 15 partnerships submitted successful proposals for the new funding cycle, including the partnerships involved in the AMR network. A further two obtained funds from other sources (RKI/Guinea for a follow-on project financed by the German Federal Ministry of Health, the German Institute for Medical Mission (Difäm) for another three-year project on IPC and AMR). Among the partnerships that are not continuing under the new funding project, one German university involved in two long-standing partnerships was optimistic about the possibility of future funding and of bridging the external funding gap in the short to medium term.

Overall rating

Based on the OECD/DAC criteria, the project overall has been rated as **successful** (average rating of the five criteria: 81.6 points).

The criteria rated as **successful** are **relevance** (alignment with the relevant strategic frameworks, orientation towards the needs of the target groups and coherence of the results model), **effectiveness** (goal-attainment at the level of the overall TC measure and the funded projects, with a confirmed high contribution of project interventions to achieved results), and **impact** (assessed for health-related results on one hand and contributions to health-system strengthening on the other).

Criteria rated as **moderately successful** were **efficiency** (output/resource ratio, allocation efficiency, including synergies with regional or bilateral TC measures), and **sustainability** (mechanisms for anchoring results in the partner structures and forecast of the durability of results).

Rating OECD DAC Evaluation Criteria

Criteria	Score Points / 100	Rating 1 (highly successful) to 6 (highly unsuccessful)
Relevance	87	Level 2, successful
Effectiveness	85	Level 2, successful
Impact	81	Level 2, successful
Efficiency	80	Level 3, moderately successful
Sustainability	75	Level 3, moderately successful
Overall	81.6	Level 2, successful

Conclusions and factors of success and failure

Institutional health partnerships have a long history, and past studies and evaluations have generated broad knowledge on a range of success factors. The following factors were particularly highlighted during this evaluation:

- ✔ long-term perspective of the partnerships and access to consecutive funding,
- ✔ needs orientation through participatory planning and sound situational analyses,
- ✔ 'built-in redundancy' capacity to compensate for high staff turnover,
- ✔ definition of realistic goals, avoiding overambitious targets for the type of project and
- ✔ emphasis on research components as the area where the principle of reciprocity can best be promoted.

Critical factors were:

- ✘ time limitations due the funding period,
- ✘ staff turnover in African hospitals,
- ✘ adverse external events, e.g. unrests or strikes,
- ✘ institutional commitment affected by changes in leadership,
- ✘ administrative bottlenecks,
- ✘ complicated procedures for importing goods procured by the projects and
- ✘ limited availability of personnel resources from German partners beyond initially specified in-kind contributions.

For the overall project, the following success factors were highlighted:

- ✔ pertinence of the patient safety funding topic,
- ✔ focus on German partners with high expertise levels and systemically relevant African partners
- ✔ technical support, in particular for networking among partnerships and with external stakeholders,
- ✔ ability to liaise with bilateral and regional TC measures, resulting in good practice examples (e.g. in the case of Guinea) and
- ✔ creation of an e-learning course on patient safety at Heidelberg University as a learning resource available beyond the duration of the TC measure.

Recommendations

Continuity of funding for university and hospital partnerships: The university and hospital partnerships showed significant potential to leverage expertise otherwise unavailable to German development cooperation and to strengthen key African partners with spill-over and multiplier effects in other segments of their health systems. The evaluation therefore recommends continued funding of IHPs.

Continuity of focused but sufficiently flexible funding topics: The patient-safety funding topic provided a clear strategic focus while allowing for a broad spectrum of project measures. Most interviewees agreed on the pertinence of setting overarching topics using similar criteria for future funding cycles.

Identification of partnerships during the appraisal instead of an 'in-project' selection process: To fully exploit the three-year project term of a TC module, partnership projects could be identified during appraisal of the TC module to maximise the time frame available for implementing the partnership projects. Focusing on established (thematic) partnership networks could enhance synergies.

Interconnections and boundaries between the two TC projects for funding IHPs: Whereas the two projects for funding international health partnerships have clearly distinct characteristics, the complementarity and/or boundaries between the two approaches have not yet been fully conceptualised. Clarifying the interconnections and boundaries is recommended.

Synergies with other TC instruments: The presence of integrated experts in related institutional and technical areas has proven potential to benefit partnerships, including in (a) facilitation of participatory, needs-based project design, (b) continuity of project activities between intermittent visits by German partners, (c) strengthening interconnections between projects and health systems and (d) increasing the scope of the capacity development components of partnership projects. Complementing partnership projects with integrated experts is therefore strongly encouraged.

Dissemination of experience gained and lessons learned within the German development community: Interviews with GIZ staff involved in bilateral and regional projects revealed a demand for further information on good practices, experience gained and lessons learned from hospital partnerships. The evaluation recommends that further emphasis is given to proactive knowledge management for the German development community.

Approach and methods of the evaluation

This evaluation was conducted in line with the OECD/DAC relevance, effectiveness, efficiency, impact and sustainability criteria. To adequately anticipate results and direct the focus of data collection and analysis, a theory-based approach based on a reconstructed results model was applied.

The evaluation design is predominantly based on secondary analysis of the progress and final reporting of the partnership projects and key informant interviews with (a) representatives of German health institutions involved in university and hospital partnerships, (b) staff of the project, (c) representatives of bilateral and regional health sector TC measures in the project region, (d) representatives of other areas of GIZ involved in the subject area and (e) further stakeholders such as BMZ and other funding agencies (e.g. DAAD, BMBF, ESTHER Switzerland).

The evaluation phase coincided with the initial phase of the coronavirus pandemic, which significantly hampered implementation of the planned evaluation design. 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:

- ☑ 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).
- ☑ Due to the crisis situation, it was considered neither realistic nor pertinent to contact African hospitals directly; after prior consultation with the German partner hospitals, only one African partner hospital was included.
- ☑ Interviews with GIZ were carried out as planned.
- ☑ Interviews with other stakeholders (mostly carried out before the pandemic) were not affected.

Rating system

Projects are rated based on the OECD/DAC criteria of relevance, effectiveness, impact, sustainability and efficiency. Each of the 5 criteria is rated on a scale of 1 to 100 (percentage system).

The project's overall score is derived from the average points awarded for the individual DAC criteria. The average value for the overall score is rounded according to mathematical convention. All DAC criteria are equally weighted for the overall score. Compared with the predecessor systems (6-point scale, 16-point scale), a 100-point scale has a number of advantages in that it allows greater differentiation, is commonly used internationally, is easy to understand and can readily be converted into other assessment systems.

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

Rating system

Both the assessment dimensions within the OECD/DAC criteria and determination of the overall score using a points system serve to increase the transparency of ratings, whilst enabling better comparability between individual projects.

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