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EVALUATION REPORT

EUROPEAN ESTHER ALLIANCE: STUDY
ON BEHALF OF: THE ESTHER ALLIANCE

MAY 2013

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“The relationship between Europe and the world has changed a lot over the past 10-20 years. Twenty years ago we could still think that the whole world depends on Europe and the United States for its development, for its improvement of the lot of poor people. Right now, we are in a situation where Europe actually depends more on the world for its own growth, its economic and social development, than the other way around.

*We now have Southern partners who are increasingly vocal about their own wishes, their own rights, and their own plans. They are less and less willing to accept ‘recipes’ from either Europe, the US or elsewhere for their development. Therefore the relationship, in a very positive way, has become a lot more **reciprocal**, and much more **equal**. That makes international cooperation more interesting, vital and dynamic, because now we are really sitting around the table and nobody has to take anything at face value from other parties.*

People want to hear our experiences so that they can think about it, reflect on it, see whether at this time, in this moment, they can learn something from it and apply it to their own development.”

Paul Engel, Director of The European Centre for Development and Policy Management (ECDPM)
<http://www.ecdpm-talkingpoints.org/audio-thoughts-on-europes-relationship-with-the-world-from-ecdpm-director/>

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ACRONYMS

CPD	Continuing Professional Development
CME	Continuing Medical Education
DC	Development Cooperation
EEA	European ESTHER Alliance
HSS	Health Systems Strengthening
M&E	Monitoring and Evaluation
MLIC	Middle and Low Income Countries
MoH	Ministry of Health
NCD	Non Communicable Disease
NGO	Non Governmental Organisation
OECD/DAC	Organisation for Economic Development/Development Assistance Committee
PMTCT	Prevention of Mother to Child Transmission
SOP	Standard Operating Procedure
TA	Technical Assistance
WHO	World Health Organisation

DEFINITIONS

Coordinating Body	Institutions that have been mandated by their government to implement partnership programmes. They may be public or private bodies.
Government Representative	Representatives of the member governments who are regularly involved in ESTHER meetings.
ESTHER Initiative	European ESTHER Alliance and its members' bilateral partnership programmes
Implementing Partners	Institutions in the north and south that are partners within the bilateral programmes of EEA members.
Institutional Partnership for Health	Long-term collaboration between service delivery and professional development institution within the health sector.
Members	Members of the European ESTHER Alliance.
Partnership Programmes	Funded programmes, delivered through institutional partnerships for health.

Note on terminology

In the report a distinction is made between the EEA or Alliance, which is the collaboration of all members and ESTHER which is used to refer to the model of working through institutional partnerships for health. When referring to individual member ESTHER programmes we refer to these as bilateral partnerships programmes.

A distinction is made between coordinating bodies (ie those responsible for the facilitation of partnerships) and government representatives although in some cases the coordinating body is a government institution.

EXECUTIVE SUMMARY

The ESTHER initiative is a unique alliance of European countries that have a common aim to improve health outcomes in low and middle-income countries by strengthening the capacity of health professionals through institutional partnerships. Institutional partnerships for health in this report are defined as long-term collaborations between service delivery and professional development institutions within the health sector. The development cooperation landscape is rapidly evolving and it is an important time for the European ESTHER Alliance to collectively review their current mode of operation and opportunities for the future. Whilst this study explored the commonalities and challenges for bilateral partnership programmes and lessons from northern and southern implementing partners the main focus is on:

- the added value of institutional partnerships for health;
- the added value that the Alliance brings;
- future options for the Alliance.

The findings are based on document review and interviews with ESTHER members, southern government representatives and northern and southern implementing partners.

There is a need for the institutional partnership model to move from faith to science. The institutional partnership movement needs to understand why interventions work and underpin this with a robust evidence base. This would form a key foundation from which to advocate and bid for new funding within a results-based agenda. This evidence base will also enable bilateral programmes to make robust arguments for continued funding and form the basis of proposals for external funding. The European ESTHER Alliance has the opportunity to play a key role in the knowledge generation required to underpin the institutional partnership model in development cooperation in health.

Although health systems strengthening is one of the overarching objectives of the EEA, this study found that there was not a shared understanding of how institutional partnerships contribute to health systems strengthening. The various models of bilateral partnership programmes have different intensities and routes to influence health systems, but as of yet, many of the bilateral programmes have not fully realised the potential for health systems strengthening. Further work is needed to ensure that all bilateral partnership programmes maximise their impact on health systems.

The work of the Alliance should be differentiated from members' bilateral partnership programmes, focussing on areas where it can add value, whilst allowing the diversity of approaches to enrich and generate new knowledge. Identified areas of added value for the EEA are:

- Knowledge generation on institutional partnerships in health;
- Advocacy for institutional partnerships to be recognised as a valid form of development cooperation;
- Creation of an enabling environment for joint programmes of work between members;
- Promoting adherence of current best practices within ESTHER partnerships.

Knowledge generation should be prioritised to improve visibility and as a foundation for joint programmes of work and validation of best practice.

Members need to unite behind a shared strategic vision of the future of the Alliance that is valued by them. As added value is realised it should increase the commitment of members to the Alliance, a prerequisite for putting the Alliance on a firmer financial footing in the future. Delivering this added value should also make the Alliance attractive to new members and other key international organisations and stakeholders.

The ESTHER initiative is best placed within the development cooperation landscape as a niche provider. Emerging and existing areas where ESTHER can deliver include:

- a. Institutional strengthening of key national and regional health institutions;
- b. Strengthening medical education and continuing professional development;
- c. Quality improvement of health service delivery;
- d. Building capacity in operational and implementation research;
- e. Building capacity in non-communicable diseases;
- f. Contributing to universal health coverage.

The ESTHER initiative is delivering partnerships that have benefits beyond traditional forms of technical cooperation and provides access to practising health professionals not easily accessed through technical assistance, supporting parts of the health service often overlooked by donors. It is an approach which is particularly valued by southern governments and implementing partners. These peer-to-peer partnerships are capable of inspiring institutions and individuals to change the way they work and improve quality of service delivery. The ESTHER initiative undoubtedly has a niche within which it can add value to the development cooperation landscape.

BACKGROUND

The European ESTHER Alliance is a network of governments and their institutions and organisations. It mobilises health expertise and health partnerships to contribute to the global health agenda as a component of development cooperation with middle and low-income countries.

In 2002, France launched the ESTHER Initiative (Together for a Networked Hospital Therapeutic Solidarity), with the main goal of strengthening the capacities of low-income countries to combat HIV/AIDS and related diseases. A European Secretariat was established in France in 2002 by agreement of the first 4 member states. The Alliance currently has 12 members (Spain, France, Italy, Luxembourg, Germany, Austria, Belgium, Portugal, Greece, Norway, Switzerland and Ireland) of which Switzerland and Ireland are its newest, joining in 2011 and 2012 respectively. All members have signed a ministerial declaration of engagement to develop the initiative. The United Kingdom joined the EEA with observer status in October 2012.

Since its creation in 2002, the European ESTHER Alliance has evolved and broadened its scope, scale of activities, modus operandi and size, moving from a primarily HIV/AIDS-based focus, to include other health priorities that contribute to the achievement of the Millennium Development Goals. Its overall aim is to contribute to health systems strengthening through country partners to improve health outcomes. In 2012 Alliance members were active in 41 countries in sub-Saharan Africa, North Africa, Central and South America, Central and South-East Asia. This has resulted in multiple programmes/projects encompassing a wide range of twinning activities and training for hospital professionals (physicians, nurses, biologists, virologists, lab technicians, pharmacists, hospital management teams, and more) in 331 sites. Foci of interventions have included prevention of mother to child transmission, paediatric care, quality improvement and safety programmes, psychosocial activities, operational research, monitoring and evaluation, laboratory support, mother and child health, technical assistance at country level, support for post-graduate qualifications and collaboration with civil society organisations.

PURPOSE AND SCOPE

The purpose of the study was to conduct a qualitative evaluation of the ESTHER initiative, at both European level and country implementation level, capturing both the achievements and challenges faced by the EEA since its inception and looking towards the future in how best the EEA can position itself with the development cooperation landscape. This evaluation has focused on:

- Identifying the added value of institutional partnerships for health;
- identifying and analysing the added value that the Alliance brings as a European platform for development cooperation in health;
- presenting future options for how best the Alliance can advance and position itself within the development cooperation landscape;
- identifying the commonalities and challenges for Alliance member bilateral partnership programmes;
- evaluating the reported contributions that northern and southern partners have made to health systems strengthening and improved health outcomes.

In addition to this evaluation report that has been written for an internal audience, a second document has been produced to facilitate visibility and advocacy both across EEA members and externally. Furthermore, a separate background note has been written that examines current thinking in development cooperation and how this relates to the EEA within a rapidly changing global health landscape. Core data from each of the members has been summarised to facilitate understanding of the different modus operandi of each national

entity and selected case-studies from implementing partners have been developed to highlight a range of partnership projects supported by the Alliance.

EVALUATION FRAMEWORK

The framework used in this evaluation study is aligned with the OECD/DAC criteria (see Table 1).

Table 1: OECD/DAC definitions of evaluation criteria adapted to this particular evaluation

RELEVANCE	The extent to which the objectives of the EEA are consistent with member country priorities, beneficiary country priorities, WHO building blocks for health system strengthening and UNDP 5 step approach to capacity development.
EFFICIENCY	The extent to which the inputs (finances, human resource and time) were expended on the planned activities and projects both by the EEA and member bilateral initiatives under EEA. Evidence of monitoring & evaluation of a work plan for EEA activities.
EFFECTIVENESS	The extent to which EEA and national coordinating bodies objectives were perceived to be achieved, or are expected to be achieved, taking into account their relative importance and changes over time.
IMPACT	The extent to which the impact of EEA initiatives has resulted in strengthened skills and capacities, and contributed to health systems strengthening as perceived by northern and southern technical partners, (quantitative evidence of impact is outside the scope of this evaluation).
SUSTAINABILITY	Plans for continuing commitment to and development of EEA and its activities.

For evaluating project implementation by the northern and southern technical partners the OECD/DAC evaluation criteria with combined with a logic model (see Annex 4).

METHODOLOGY

Priority countries that have active bilateral programmes were included in all levels of the evaluation (France, Germany, Spain, Italy, Norway and Ireland). Switzerland, Luxembourg, Greece, and UK were involved in the first stage of this evaluation and Belgium, Portugal and Austria did not participate in the study.

STAGE 1: DOCUMENT AND LITERATURE REVIEW

An extensive document review was completed based on a range of documentation (project documents, meeting reports, progress and evaluation reports, publicity materials, project presentations etc.) provided by the European Secretariat, national coordinating bodies and technical implementing partners. In addition a rapid review of the current international literature was conducted in relation to development cooperation, health partnerships, capacity development, human resources for health and health systems strengthening. This was not a comprehensive literature review but based on the consultancy team's existing familiarity with the international literature and also guided by key informants.

STAGE 2: INTERVIEWS

The majority of interviews were conducted by either Skype or telephone. All first stage interviews were carried out by 2 people and were simultaneously recorded and transcribed. Second stage interviews were conducted by 1 person and were recorded whilst simultaneously taking notes. Interview guides are included in Annex 2 and the list of interviewees is in Annex 1.

First stage interviews focused on the ESTHER model, its added value, achievements, challenges and future direction. These interviews were targeted at the EEA Secretariat, northern governments and national coordinating bodies. 24 individuals were interviewed representing the EEA secretariat (n=1), northern governments (n=10) and national coordinating bodies (n=13). In addition 2 interviews were conducted with experts working in field of institutional partnerships at a European and International level.

National coordinating bodies from the priority countries selected best-practice projects which demonstrated one or more of a range of criteria (evidence of change, innovation, potential for scale-up, health systems strengthening, sustainability, quality partnerships) to be included for interview in the second stage interviews.

Second stage interviews focused on added value of hospital partnerships. Key informants were asked to describe their experiences of working within partnerships and implementing projects and activities. They identified enablers, challenges and lessons learned in partnership working and the degree to which partnerships can strengthen national health systems. These interviews were targeted at northern and southern implementing partners and southern governments. A total of 23 interviews were conducted (9 northern implementing partners, 11 southern implementing partners, 3 southern government representatives).

STAGE 3: ANALYSIS AND SYNTHESIS OF FINDINGS

A thematic analysis using the OECD/DAC framework was used to draw out the main themes and topics arising from the Skype/telephone interviews. Data was analysed at 4 different levels:

1. Added value of institutional partnerships for health;
2. EEA level;
3. National Secretariat level;
4. Partnership/Project level (case studies and lessons learned).

The thematic analysis combined with the secondary data review of ESTHER project documentation and literature review, allowed the evaluation team to synthesise and present reported practice within current thinking and EEA objectives and guidelines. The development of narrative case studies has been used to provide concrete examples of implemented programmes, highlighting innovations, lessons learned and challenges in contributing to health systems strengthening (refer to separate case-studies report).

LIMITATIONS & CONSTRAINTS

This evaluation was constrained both geographically and in time, and is based on document review and telephone/Skype interviews conducted with a range of ESTHER stakeholders. Obtaining participation from key informants especially with technical implementing partners and southern governments proved to be extremely time consuming. Only 3 southern governments responded to requests and participated in interviews and 20 interviews were conducted with northern and southern implementing partners. Therefore it should be recognised that these perspectives do not fully represent the range of views and experiences of those participating in the ESTHER initiative.

Data analysed in this study was primarily qualitative, relying on reported activities and perceptions of relevance, achievements, impact and added value. Objective verification of these concepts was outside the limits of this evaluation. Secondary project data used in this study has not been verified for data quality and integrity.

Objective comparison of the EEA model with other forms of development co-operation was beyond the scope of this evaluation, however perceptions of added value from partners involved in other donor funded initiatives was obtained. Whilst criteria for examples of best practice projects were developed and agreed, projects were identified by national secretariats and may be subject to bias. The subsequent case-studies developed, were based on document review and interviews with one-three persons from each partnership and are also subject to bias. Descriptions of the individual ESTHER entities were dependent on the completeness of information provided by the secretariats.

FINDINGS

The findings are summarised in four sections:

Section 1: Explores the role of institutional partnerships for health in development cooperation.

Section 2: Evaluates the work of the European ESTHER Alliance from the perspectives of its members and southern government representatives. This section does not evaluate the individual members bilateral partnership programmes.

Section 3: Examines some of the best practices and common challenges of the bilateral partnership programmes from the perspectives of EEA members.

Section 4: Summarises enablers, barriers and key lessons learned from the technical implementing partners.

SECTION 1: THE ROLE OF INSTITUTIONAL PARTNERSHIPS FOR HEALTH

The section describes the role and benefits of working in partnership and its place within bilateral development cooperation, based on key informant perceptions.

Looking at it now, we think that we have one health and that the world is becoming one global village, then it is important to have these partnerships Southern Government Representative

1.1: WORKING IN PARTNERSHIP

Some of those institutions where we have seen really vibrant twinning relationships - they stand out that something happens in those institutions and it is not just the equipment or training programme - something else happens, there is a different atmosphere. Northern Government Representative

Key informants stated that institutional partnerships for health have a benefit beyond traditional forms of technical assistance (TA) that commonly centre on short term filling of capacity gaps. These benefits included:

- institutional strengthening in a way that traditional TA cannot or rarely achieve;
- responsiveness to local needs and promoting local ownership;
- long-term approach which builds trust and capacity;
- peer-to-peer multidisciplinary learning and exchange;
- mutuality and exchange of experiences and expertise;
- solidarity within global health;
- enabling innovation and experimentation in health service delivery;
- ability to fund interventions which are not usually funded in development cooperation (eg trauma, palliative care);
- an opportunity to bring learning to the north of how to manage with less resources;
- an opportunity for health workers in the north to gain experience with conditions not usually presented in the north;
- an opportunity for health workers in the north to learn cultural sensitivity which then is useful in working with migrant populations in their own services.

There was widespread endorsement of ESTHER's approach to partnership - capacity building and sustainable improvement rather than substitution or gap filling.

Southern government representatives saw the value in partnerships as peer-to-peer exchanges that provide an opportunity for capacity building, knowledge sharing and technology transfer.

There is something quite powerful about doctors and nurses who are doing the job somewhere else going and working with someone in another country– you are working with peers – they understand each other.

Coordinating Body Representative

1.2: NEED TO BE WIDER THAN HOSPITALS

The future of partnership work is not just in hospitals. Where does primary care and public health fit in? ESTHER members also need to respond to the Universal Health coverage agenda.

Coordinating Body Representative

Many noted that partnerships with institutions other than hospitals are of value but that hospitals are a vital often neglected part of the health system and should remain central to the ESTHER strategy. Whilst members did not offer a definition, the most common term used to describe partnership working was ‘institutional partnerships’ to distinguish the fact that these were not just between hospitals. With the current drive towards universal health coverage, EEA members were keen to explore how partnerships could be used to reach primary health care and community level, but recognised that this was more operationally challenging than hospital-to-hospital partnerships. However, as decentralisation is a key strategy for effective health services in low and middle-income countries, a focus on lower levels of the health system was seen as an important future area for ESTHER to consider. Other areas that members felt were important to explore included partnerships between professional associations and institutions with a regional focus, and south-south or south-south-north collaborations.

1.3: ROLE WITHIN DEVELOPMENT COOPERATION

If you only had one way to strengthen the health workforce you would not do it through hospital partnerships, but with a robust strategy it is a very legitimate complementary or extra strand that can try out things that may not be happening in more conventional bilateral programmes.

Northern Government Representative

Many government representatives felt that institutional partnerships worked best alongside more traditional forms of development cooperation. Hence institutional partnerships were seen as a complementary addition to the toolbox of development cooperation but not a substitution. They were also seen as low cost.

Some concerns regarding implementation of partnership programmes included:

- contribution to aid fragmentation and proliferation of aid actors;
- the degree to which partnerships are southern-led and aligned with government priorities;
- the degree to which partnerships are able to contribute to health systems strengthening;
- the use of well-intentioned, development-naive volunteers, resulting in unintended costs or harms;
- creating pockets of excellence that have the potential to become overloaded and victims of their own success.

I would love to think more about how you can best work in alignment and more constructively with impact and sustainability within government systems.

Northern Government Representative

1.4: PARTNERSHIPS AND HEALTH SYSTEMS STRENGTHENING

We are in a development approach not a substitute approach. So for it to be effective we have to consider how do we strengthen the system.
Northern Government Representative

There were different opinions amongst key informants about how health partnerships contribute to health systems strengthening. For some, any contribution made to workforce development and training inferred an impact on the health system, even if it was only working within one department of a hospital or focussed on a single clinical area. For others, a systems approach was vital to successful institutional strengthening, in that a hospital could only improve its performance if all six of the WHO health systems building blocks were addressed. Others identified the importance of undertaking operational research within partnerships to improve implementation know-how and demonstrate efficacy of interventions in specific contexts. Some distinguished two routes to health systems strengthening: the first being through pilot projects where experimentation could be used to influence national policy; and the second as a larger programmatic approach implemented through national programmes. Another perspective was that it was overambitious to think that health partnerships could contribute to health systems strengthening and that the key role was to strengthen institutions within the health system. Health partnerships were perceived as strengthening the backbone of their health system by one Southern Government representative, whilst another saw it as having the potential to strengthen district and regional hospitals, which form the basis of a robust district health system.

1.5 ANALYSIS AND RECOMMENDATIONS

We need to ensure much more sophistication about what it means to work in a health system.
Northern Government Representative

The European ESTHER Alliance should agree common terminology to describe the partnerships managed by their members to ensure that it encapsulates the different types of institutional partnerships practised both currently and in the future. For future funders it is important that the EEA is presented as being able to manage a range of appropriate partnerships for future global health challenges. Current terminology used by members included hospital partnerships, institutional partnerships (for health) and health partnerships.

It is of fundamental interest to ESTHER members and the EEA collectively to clarify and develop their thinking as to how institutional health partnerships can contribute to health systems strengthening and improved health outcomes. For donors and other funding bodies the combination of an intervention that has high impact with a low cost would be a highly attractive investment. Hence, understanding how different partnerships models interact and how they can influence the health system is of key importance. The various models and approaches used by EEA members have different intensity and routes to influencing health systems but each needs to demonstrate this in order to reinforce their utility within the development cooperation landscape.

There is a need for the partnership model to move from faith to science. To date much of the funding for partnership initiatives has been based on a belief that this form of work offers a range of benefits (such as those identified by EEA members) and that the funding available to individual bilateral programmes is largely dependent on the degree to which politicians share this belief. There is a lack of rigorous evaluation material that assesses their impact. The partnership movement needs to develop a coherent theory of change and underpin this with a robust evidence base. This would provide a foundation from which to advocate and bid for funding in which a results agenda is in ascendance. This evidence base will enable bilateral programmes to make robust arguments for continued funding and form the basis of proposals for external funding.

Key Recommendations

1. EEA should agree a common terminology for partnership working that encompasses partnerships beyond hospitals.
2. The ESTHER Initiative should recognise their contribution to Health Systems Strengthening and performance at different levels (institutional, district/regional and national level). There is a need to articulate more clearly the theory of change as to how these levels contribute to health systems strengthening which can provide a more robust evidence base.
3. Further work on the conceptualisation of the added value of health partnerships is required paying particular attention to donor concerns. This can form the basis of a joint research strategy to seek funded research proposals that underpin the case for health partnerships as a valid form of development cooperation.
4. Commissioning value for money studies on the EEA's different partnership models of working would allow ESTHER to demonstrate to donors and other funding bodies the impact and cost of existing programmes.

SECTION 2: EUROPEAN ESTHER ALLIANCE

This section of the report evaluates the European ESTHER Alliance - based on members' perceptions - within the evaluation framework of relevance, efficiency, effectiveness and discusses options for the future of the Alliance. Individual bilateral partnership programmes are the focus of Section 3.

2.1 RELEVANCE

Relevance is examined in relation to perceived added value that the alliance affords its members, the extent of political will to support a European ESTHER Alliance and whether members identify with a shared vision for the Alliance.

2.1.1 Added Value

It is nice to be part of a European alliance – they can meet with other people involved in their area of interest – this is already something good. With the platform we have set up, people know each other and it facilitates exchanges, there are links between people (information, networking, connection at the technical level).

Coordinating Body Representative

The majority of first stage interviewees agreed that the Alliance was of value to them, whilst at the same time recognising that much of the potential of the EEA was unrealised. The potential and realised added value could be categorised into four areas:

- networking, information exchange, learning and knowledge generation;
- coordination, collaboration and joint projects;
- visibility and advocacy;
- validation and mandate.

There was significant agreement among members of the alliance that all were committed to the concept of institutional partnerships for health and that the meetings were vibrant and interesting. It was acknowledged that new EEA members have given the Alliance an increased energy, with working groups established in areas of mutual interest including quality of partnerships, M&E and operational research.

Networking and information sharing were identified as being the most realised whilst joint projects and coordinating and joint working was an area where members described the most unrealised potential. The importance given to validation and mandate varied widely dependent on the political realities of the different member countries.

You can see this in the reports, there is what one country does, what another one does, its history, the effectiveness, efficacy, the actions, the projects of the national network, but we have difficulties in seeing the added value of integration of the national networks within ESTHER.

Northern Government Representative

2.1.2 Political will for European Alliance

For some of the countries it seemed to give them momentum as the government gave them a mandate, but for other countries that had signed up, it was not central to what they are doing.

Coordinating Body Representative

Founding members and early joiners described a clear link between the political mandate for joining the EEA and the release of resources to support institutional partnerships for health. However, this is increasingly not

the case. The economic crisis has resulted in cuts or cessation of funding bilateral partnership programmes for many of the member countries. New members including Switzerland and Ireland have had very minimal administrative funding on the back of political commitment, but no funding guaranteed for partnerships themselves; although there was discussion that this was the first step towards achieving a funded partnership programme.

The newest members talked about the importance of using the ESTHER brand as a way of validating partnerships based on best practice and that the political commitment gave this brand additional weight.

For countries, such as the UK, which already have a long standing partnership programme, achieving ministerial sign up to the Alliance would depend on a much stronger demonstration of added value than was currently available. In general, government representatives were most vocal about the need for the EEA to demonstrate added value as a prerequisite to expanding support (financial or members).

We tried a few times to get political people interested. They were interested but not enough. It is difficult to go further without political will - but we need to start from where we are. So we need to put something down which is more sexy for the politicians.

Coordinating Body Representative

2.1.3 Shared Vision

The different members have very different histories and often different foci in their programmes. And the lack of strategic direction is really one big challenge. EEA members are aware and it is not an easy one.

Northern Government Representative

Whilst all the members have signed up to a charter of underlying principles that they agree to uphold in their bilateral partnership programmes there is no overarching vision for the Alliance itself. The wide variation in institutional and political frameworks within which the bilateral partnership programmes operate makes it unlikely that the members of the Alliance could create one common modus operandi across their programmes. The EEA has unique access within its membership to a diversity of approaches which offers a rich resource for knowledge generation, but this is not without its challenges.

At the same time there is a consensus that a coordinated Alliance could add value to members, but change is necessary for this to be realised. The economic crisis has deepened the imperative of seeking external funds for members keen to continue partnership programmes. Most members thought a coordinated approach increased the chances of success in attracting funds. Hence, although there is not yet a shared vision of how the alliance should function in the future there is a common goal in seeking opportunities to put partnership programmes on a more sustainable footing.

Why did we think of restructuring the network? Because there are problems of financing of these initiatives, and it has to be more targeted independently of the possibility of each country's ability to plan its specific actions. In my view these are the organization's problems that necessitate a change.

Northern Government Representative

2.1.4 Analysis and Recommendations

The first priority for the EEA must be to seek a stronger and more explicit agreement amongst the membership on a shared vision for the future based on the value it can add beyond the bilateral partnership programmes. The Charter provides a solid foundation for underpinning their partnership work, but the Alliance needs its own strategic vision and plan to enable forward momentum. To date much energy has been invested in discussions about the legal institutional framework for the Alliance and in trying to better align the bilateral programmes.

This, however, may be a step further than the membership is able to take without a clear vision and a strategic framework of where the Alliance is heading.

The four areas of added value that the alliance could contribute to beyond what is possible for the bilateral programmes alone, provides areas of future focus. These are not mutually exclusive, but rather have the potential to build on each other. For example, if members work together to generate knowledge on the role of institutional partnerships in addressing global health problems, the visibility of the alliance is increased, the process of working together on knowledge generation builds better working relationships between the members and the knowledge generated can be used to support joint funding proposals which in turn increases the Alliance's visibility.

A potential strategic framing drawing on the areas of added value identified by the members might be:

An alliance that brings together European governments and their institutions to develop capacity in service delivery and operational/implementation research, through institutional partnerships that strengthen health systems and improve health outcomes. The Alliance has four aims:

1. To generate knowledge and learning on institutional partnerships in global health;
2. To advocate for institutional partnerships to be recognised as a valid form of development cooperation, which strengthens the overall response to global health problems;
3. To create an enabling environment for joint programmes of work between its members.
4. To promote the adherence of current best practices within ESTHER partnerships.

The work of the Alliance itself should be differentiated from the bilateral partnership programmes of the membership - focussing on the areas where it can add value whilst allowing the diversity of approaches to enrich and generate new knowledge. The resulting overarching vision would enable the Alliance to decide on a strategic set of actions to achieve agreed objectives. It will also inform what type of structure and membership will best support the strategic framework.

Initial time and effort should be placed on those actions which form the foundation for medium term goals rather than trying to achieve everything at once (see Figure 1).

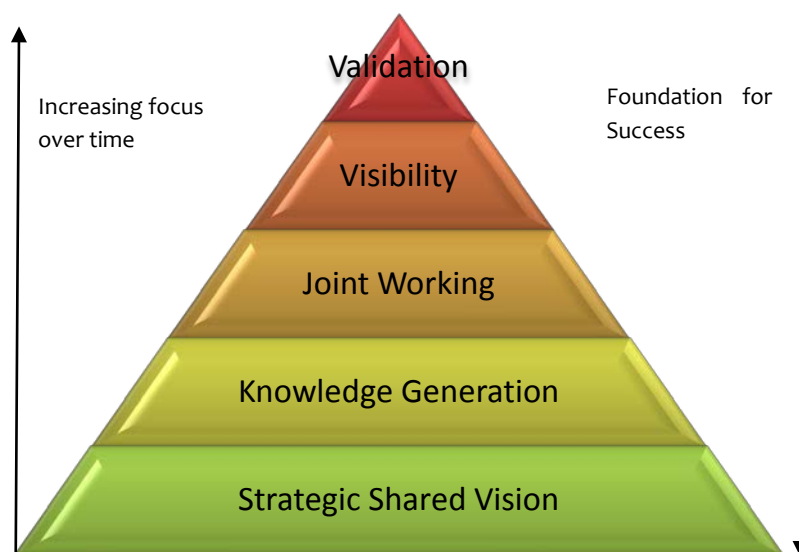


Figure 1 Foundations for Achieving Added Value for EEA

I think the Secretariat carries out a good job, but other mechanisms of exchange of experiences and coordination further than the meetings is required. We are trying to cover many things - which may dilute the main objective of the Alliance of training of professionals and the relationship of hospitals to hospitals.

Coordinating Body Representative

Key Recommendations

1. The members of the EEA should conduct a visioning workshop based around the four added value themes from this evaluation, which should lead to the development of an Alliance strategic vision and plan for the next 5-years.

2.2: EFFICIENCY

This section looks at the current resourcing and institutional structures of the EEA.

2.2.1 Institutional Structure

Other people liked the fact that it was unstructured. But at some point it is a limitation.

Coordinating Body Representative

The current structure of the EEA allows great flexibility in terms of both how members structure their bilateral programmes and the level of commitment (financial and time input) that they give to the Alliance. Members viewed this both as a strength and a potential source of fragility. There was no consensus as to whether or not a loose or tighter structure was more desirable, or whether a legal entity was necessary. In the current economic client, some countries stated that the likelihood of gaining a mandate from their government to increase their obligations (either financial or otherwise) to the Alliance was low. Recent discussions regarding forming a European Economic Interest Group had resulted in a decision not to go ahead but instead, to work together in consortiums to bid for external funding.

More pragmatic view may be to build on what we have now.

Coordinating Body Representative

2.2.3 Resourcing

Today it is quite fragile. People have willingness to be together so the will is there but the means is not enough. It takes time to develop joint activities and even joint projects. Joint projects are very time consuming.

Coordinating Body Representative

There was broad agreement that the Alliance is currently under-resourced, both financially and in terms of human resources. Recent activity of the working groups was seen as a positive step forward for joint action. However, most members are focussed on their bilateral programmes, and given the economic crisis are anxious that additional funding from bilateral partners will not be easily accessible. Greater commitment and responsiveness to the European level was seen as vital if the Alliance was going to reach its potential.

2.2.4 Analysis and Recommendations

The suggestion that the structure and organisation of the Alliance should ideally be derived from the strategic framework and vision has already been presented. For example, if advocacy with the EC is the primary added

value of the Alliance, then to be effective, the Alliance would need to employ an advocate to be based in Brussels. However, given the level of resourcing currently available to the secretariat, it may be more pragmatic to strengthen the existing structure and review new structures in the medium term.

The working groups have resulted in a recent spate of productive activity and this model would seem to be worth replicating for other areas of added value. For example, there are arguably strong reasons for setting-up a working group on external funding.

A stronger commitment to a shared vision for the organisation and resultant increases in resource commitment (financial or otherwise) will depend largely on how successful the Alliance is in persuading its members that it is capable of delivering added value. The first step of reaching agreement on a shared vision based on added value is also a crucial step to gaining deeper commitment to action from the membership itself. Once added value begins to be demonstrated it will become easier to make a business case for funding. Members will need to make firm financial and time commitments in order that the Alliance can continue to develop and deliver. The current Alliance model does not demand this type of commitment. In the meantime where there is commitment to joint activities, additional funding from members may need to be sought for those specific activities - this has been a tried and tested method for recent joint activities such as the ICT survey.

Applications for joint activities whether knowledge generation, research or joint action could include a coordination role for the ESTHER Secretariat, thus providing an additional source of income generation. This would allow joint action to be tested without having to take the step of forming new institutional structures, although this may still be of operational utility later down the line, once a solid-base of joint activities are actively being managed and delivered.

Current effort should be directed towards agreeing the strategic vision, developing and implementing the knowledge generation strategy and creating an enabling environment for joint projects rather than extending the membership. There is an opportunity cost in investing scarce resources into expansion when there is fundamental work that needs to be done underpin the strength of the Alliance. An initial focus on identifying and delivering added value for the existing membership will make it easier to attract and retain new members. The strategic vision and the experience of collaborating on new projects and research will also allow the members to review the membership criteria in the future.

Currently the membership criteria for the EEA includes 'Observer Status' which allows THET to participate in EEA meetings and activities. THET is a UK-based NGO, currently mandated to deliver the UK health partnership programme on behalf of the UK government. In the future consideration could be given to developing a second tier of membership of 'Institutional Member Status' and hence attract NGOs active in Europe in institutional partnership development. This would potentially increase the number of members who would be actively interested in developing programmes of joint action and knowledge generation.

For lean organisations it is particularly important to only focus on those activities that are likely to achieve core objectives. Many organisations spend a large proportion of their time on activities that do not get them any closer to achieving their aims - this is known in management literature as the 80:20 rule - 20% of our actions result in 80% of our results. Hence once the core aims of EEA have been agreed there is an opportunity to ruthlessly revisit the activities undertaken by the secretariat and members and ensure that they are only undertaken if they are going to help achieve those aims. This is a fundamental process in the attainment of organisational efficiency.

Key Recommendations

1. Once agreement has been reached on the core areas of focus for the Alliance, working groups should be established that mirror these agreed strategic objectives (ideally no more than four).

2. Working groups should establish an operational plan for the coming year and a 5-year strategic plan which includes key milestones and indicators against which progress and success of the Alliance can be measured.
3. In the medium term members will need to make a financial and time commitment to the Alliance to enable it to deliver and develop.
4. Applications for joint external funding (research, knowledge hubs, programmes) should include a costed coordination role for the EEA Secretariat contributing to its future income streams.
5. In the longer term, consideration could be given to expanding the membership base to include 'Institutional Members' who align with EEA strategy.

2.3: EFFECTIVENESS

This section examines the achievements of the EEA using the four areas of added value identified earlier in this report. Achievements of the bilateral partnership programmes are examined in the next section of the report.

2.3.1 Networking, information exchange, learning and knowledge generation

The variety of models does not matter to me. From my point of view it is enriching and how we can learn from each other. If we all do the same thing then the Alliance would not have a meaning or a reason for existence.

Northern Government Representative

There is an excellent record of attendance at EEA meetings. The vast majority of the members who regularly attended EEA meetings found the networking and information sharing of value. The outputs of the working groups in terms of the Self Assessment on the Quality of Partnerships and the ICT survey were also widely welcomed and thought to contribute to learning and knowledge generation.

A widely held view was that most interaction remained at the level of information exchange and that the Alliance still had untapped potential to move beyond this into learning and knowledge generation, potentially acting as a knowledge management hub.

For some members the opportunity to network, exchange information and learn from each other was sufficient *raison d'être* for the Alliance. For most, however, the possibility of joint projects and collaboration was central to their conception of the EEA.

I sense a change in that all the members are impatient to see joint action rather than just exchange information.

Coordinating Body Representative

2.3.2 Coordination, collaboration and joint projects

Joint working is what will make the Alliance real and visible.

Coordinating Body Representative

To date there has only been limited collaboration between ESTHER members in terms of joint projects and action. Whilst there is significant agreement that this is desirable there is also a shared understanding of the numerous barriers that need to be dealt with to make this a reality. Barriers to cooperation identified include:

- different models utilised within the member bilateral programmes;
- limited understanding and knowledge about other member's activities;
- lack of geographical overlap in active countries;

- diverse languages;
- absence of common thematic focus;
- lack of capacity to put together joint bids;
- cooperation needs to work between the implementing partners not just the EEA members;
- need for collaboration to be southern-led;
- specific institutional barriers to cooperation in some countries.

The aspiration for joint projects was not only strong amongst those members who do not currently have funding for their bilateral programmes but was also recognised as being a potentially effective way of “stepping-up” to another level, among existing bilateral funded programmes. This was strengthened by the recognition that current levels of bilateral funding were not guaranteed in the future.

Immediate areas of cooperation identified by members included operational/implementation research and strengthening medical education through E-Learning.

For some members their ultimate goal was to build a combined offer of expertise from across Europe to meet southern needs. Others spoke of being able to divide responsibility for delivery of projects between the member countries, playing to particular strengths and different operating models.

Our expectation is not so much to get access to funds now but rather to find a common strategic direction which then as a second phase would make it easier to access funds.
Northern Government Representative

2.3.3 Visibility and advocacy

At the national level I think the alliance has clear visibility; but at the international level, with the EU and WHO, we need to increase the international visibility. This is not increasing the visibility of individual countries but the visibility of the alliance as a whole.
Northern Government Representative

The EEA has a website and promotional materials. The website has been designed so that individual members can take responsibility for the update of their sections of the site, however, currently the information provided is incomplete.

The EEA organises joint satellites at international conferences to promote institutional partnerships and when EEA meetings are held, host countries will promote institutional partnerships nationally.

Initial discussions have been undertaken with the EC but at the current time there is no concrete agenda for collaboration. The European ESTHER Alliance is also known at WHO and is working with their Global Partnerships lead.

Whilst the ESTHER brand is well known in some European countries and within some of the key international organisations there is a recognition amongst members that visibility needs to be strengthened.

If we can do something together then it can convince people that we can do things and be visible.
Coordinating Body Representative

2.3.4 Validation and mandate

For many of the members the opportunity to be part of a European movement of partnerships programmes in international health underpinned by a charter of principles for agreed best practice was a key motivation in joining the Alliance. It gave them a framework within which they can validate partnerships as adhering to best

practice and those partnerships then became part of a European movement rather than a purely bilateral form of cooperation.

2.3.5 Growth of the EEA

I think it is very comforting idea for other countries that our model is seen as a positive one. It is a model to implement ... For me it is reassuring and a sign that it is not outdated, but is moving on and moving towards common objectives. It is very dynamic and still has lots of things to say and do.
Coordinating Body Representative

The EEA has recently expanded its membership, and this was regarded positively, since it injected a new energy into the Alliance. This expansion was also seen as vindicating the model of institutional partnerships in health as being relevant in the current environment of development cooperation.

2.3.6 Common indicators

The working group on common indicators has identified the difficulty of producing a set of indicators that would monitor outcomes and impact across all ESTHER bilateral partnerships programmes, due to the wide variation in technical themes and modes of working. Opinions as to the desirability and possibility of having a set of common indicators varied widely from those very much in support to those who thought it was unrealistic. A self-assessment tool for the quality of partnership has been developed and is being implemented throughout the Alliance.

Measurement of outcomes and impact of partnership work was also an area that implementing partners reported as being particularly challenging. Currently indicators are difficult to collect in practice and the degree of change that can realistically be attributed to partnership work is very hard to calculate.

2.3.7 Analysis and Recommendations

EEA is discussing and has a rich dialogue. But we need to move to the next step beyond the dialogue to new arrangements. Need to adapt to the international landscape.
Northern Government Representative

As with the previous discussion about added value many of the members felt that the potential of the Alliance has yet to be fully realised. There was appetite for change to work towards a situation where the EEA could achieve more of the aspirations of its members.

Whilst there is much potential for knowledge generation and learning within the network there is also limited resources available to coordinate and undertake this activity. This necessitates strategic use of the limited resources available. Within this context it is recommended that the Alliance build a knowledge generation and management strategy that supports the case for institutional partnerships within development cooperation and, where possible, applies for funding to undertake this work as research projects with a long term aim of building a reputation for being “thought leaders” in terms of institutional partnerships for development cooperation in health.

One knowledge generation strategy could be the development of a series of “praxis” papers, highlighting best practice in the facilitation and management of institutional partnerships. Implementing partners could be invited to develop papers in the series and members could also develop papers synthesizing learning from across different partnerships and bilateral programmes. Such papers would simultaneously contribute to the knowledge of ESTHER members and other institutions engaging in partnership work whilst increasing the visibility of the Alliance.

Members already have close ties with research institutions within their networks and further exploration could be made of those interested in pursuing operational and implementation research with the EEA. The particular themes of research undertaken by the EEA should be driven by both southern concerns and donor priorities (as outlined in the section above on hospital partnerships). In addition, research could also codify best practices in partnership working. In that way research can support future proposals for funding and contribute to the advocacy and visibility work of the Alliance on behalf of the partnerships model. Putting research proposals together via the working group model also contributes to the practice of collaborative and joint working.

In the future, members may aspire to be able to provide a coherent Europe-wide offer to southern countries, however, it is recognised that this is not currently realistic. The various bilateral programmes are extremely difficult to align due to thematic, geographical and institutional differences. There is still, however, great potential for subgroups of members to work together in developing proposals for funding either to particular donors or to work together in a particular country or region in alignment with southern country national plans and strategies.

There is a much greater overlap of development cooperation priority countries within the Alliance than countries with active ESTHER partnerships. One potential strategy could be to collaborate together in a particular country or region and conduct a joint multi-donor and government stakeholder meeting to ascertain how ESTHER could assist in the attainment of the health strategy. For many European countries there is greater potential to access country-based funds within priority countries than at a national level.

It is recommended that a working group on external funding is formed and that the group focus initially on creating an enabling environment for joint funding through the following steps:

- identify those members who are willing to work together to develop joint proposals for external funding;
- identify areas of shared interest - geographical and/or thematic;
- identify potential funding sources (multilateral organisations, private foundations and country-based donor and other funds) and the priorities of those particular donors/institutions and/or government(s);
- identify any additional partners who might strengthen proposals or with whom work would need to be aligned;
- identify the type and scale of resources that each collaborating country could potentially mobilise and the mechanisms for that mobilisation;
- identify the legal arrangements and potential lead institutions for proposals submitted as a consortium of members;
- agree the role of the EEA within collaborative bids and the financial model for funding that role within joint proposals.

These preparatory steps should then create a sound basis on which subgroups of countries can pursue external funding in a coordinated way.

If the Alliance is successful in undertaking joint research or projects these will, in turn, give opportunities to increase the visibility of the Alliance and the ESTHER name. A communications strategy should be developed in the medium term once joint activities have been undertaken - this should also look at the use of the ESTHER “brand” for joint actions.

In the meantime it is recommended that the website is reviewed. The content of the visibility product delivered alongside this report should be used to update information currently on the website. As the Alliance develops its knowledge generation there should be more prominence on the website to papers and research generated by the Alliance and its members. Currently the website requires project information to be uploaded by each of the members for every ESTHER project. Many of the current projects are blank and are listed as “to be completed”. This is also true for some of the country level information. It is recommended instead of

striving to ensure complete information for all projects that instead a focus on having good quality case studies of partnership should be developed. An annual case study competition could be held for implementing partners to write up their experiences as case studies - a financial prize to the partnership would add an incentive and would have relatively little cost if all active members contribute to it. This would then ensure an annual influx of new information to the website without requiring the often overloaded coordinating bodies to write it up.

Validation associated with the ESTHER brand will increase if the Alliance pursues a strategy of developing itself as having a reputation as thought leaders in institutional partnerships. In the long term ESTHER may want to consider consolidating the learning they have achieved on best practices to create a quality mark (accreditation) for partnerships that work within best practice standards.

If the EEA has its own strategic vision beyond being a supranational programme of partnerships to being a network of governments and organisations that facilitate partnerships with aims of knowledge generation, advocacy, enabling collaborative working and validating good partnerships then the indicators at the EEA level should measure its success against those aims. Aggregated indicators from the individual members bilateral programmes are useful at the EEA level for communication but realistically are not going to be able to demonstrate impact given the disparate nature of the interventions under ESTHER. Hence the aggregated indicators should be kept as simple as possible in order to facilitate their easy capture and aggregation. The most useful data for the purposes of simple and effective communication messages would include:

- number of partner institutions (in north and in south);
- countries ESTHER is active in;
- number of healthcare staff trained (by cadre);
- number of graduates of ESTHER supported qualifications (by type).

Impact and the effectiveness of partnerships is then best communicated by case studies rather than aggregated statistics given the diversity of objectives and thematic areas covered by ESTHER partnerships.

Improving the relevance, effectiveness and efficiency of M&E within partnerships could then be a focus of the knowledge generation stream of work rather than for the purposes of communication.

Key Recommendations

1. Develop a knowledge management and generation strategy that focuses resources on applying for funded research that underpins the case for institutional partnerships as development cooperation.
2. Form a working group on external funding which is initially focussed on creating an enabling environment for joint funding.
3. Review the website content in the light of the visibility document and move from seeking to have complete listings of partnerships to featuring case studies of successful partnerships.
4. An annual case study competition could be held for implementing partners to write up their experiences as case studies - a financial prize to the partnership would add an incentive and would have relatively little cost if all active members contribute to it.
5. Further simplify the aggregate information that is gathered at EEA level.

2.4: EEA IN THE FUTURE

When asked what success would look like for the EEA, a stronger common strategy, the application of partnerships to broader themes within health and joint projects were the most frequently stated responses. Figure 2 shows the responses as a word cloud with the size of the text representing the frequency of response.



Figure 2 Success of the EEA as a word cloud

Many of these aspects of the work of the EEA have already been discussed. In this section we will focus on the changing global health agenda, partnership within development cooperation and future funding sources. We will also look at the implications for the Alliance in broadening its thematic focus, enlargement and the need to demonstrate effectiveness.

2.4.1 Changing Global Health Agenda

The model of cooperation is changing and I think it is a good thing. More transversal, more human resources and also new diseases like NCDs. For the Alliance this is going to have consequences very soon so we have to adapt to these changes.

Coordinating Body Representative

Universal access, non-communicable diseases, horizontal and integrated approaches were cited by many of the Alliance members as key themes in global health in the future. Universal access and the need to engage at the primary health care level has its own challenges to the model of institutional partnerships. However NCDs and horizontal and integrated approaches are areas where members could see the value of working through institutional partnerships in addressing these issues. In addition, other areas cited included strengthening operational research, education and assisting in transition funding associated with major vertical programmes such as PEPFAR. In general members felt that the changing global health agenda was one that opened possibilities for institutional partnerships as a valid form of development cooperation in global health.

We need to analyze the changes in cooperation – I speak of the big international organizations like WHO. We need to find integration between a strategic vision of the alliance and with the strategic alliance of the big agencies.

Coordinating Body Representative

2.4.2 Broader Health Themes for the European ESTHER Alliance

The future is global health it is not vertical it is horizontal. We need to follow the move.

Coordinating Body Representative

Some of the ESTHER membership are already working in partnership on a wide variety of health themes (for example Norway, Germany, UK) whilst others have been focussed on HIV/AIDS. Some members felt that there

was still a large amount of work to be done in tackling the HIV/AIDS epidemic and that broadening the remit may spread limited resources too thinly. One theme that was advocated by many was the need to approach partnership work in a more horizontal way focusing on the institution itself. Other areas that members identified as potentially fruitful for the ESTHER model of partnership work included:

- Hospital management;
- Organisation of care;
- Hygiene and patient safety;
- Hospitals and the environment;
- Non communicable diseases;
- Maternal and Child Health;
- E-learning and CPD;
- Quality improvement.

Whilst there was a lot of talk of broadening thematic focus for the Alliance, members also spoke of the importance of the Alliance having a unique niche that differentiated it from the other development actors.

We do not have the luxury or money to get at everything. It would be nice but not achievable.
Northern Government Representative

2.4.3 Partnership within Development Cooperation

There will not be so much financial transfer of resources in the future as we are seeing now. The strength and possibilities of EEA is that of institutional partnerships- that is going to be the future anyway. I think the global village world that we live in it will only be stronger and that sort of cooperation is also what I think it what is more wanted by the south now.
Northern Government Representative

The majority of members felt that the term hospital twinning or hospital partnerships no longer covered the range of partnership opportunities in global health. Preferred terminology used was either institutional partnerships for health or partnerships for global health.

There was also a shared perception that the partnership model was being noticed and seen as an interesting way of delivering change. This was connected to it being a more acceptable form of technical cooperation to southern governments - an opinion which was corroborated by our interviews with southern government representatives. However, the danger of contributing to negative aspects of development cooperation such as aid fragmentation and competition amongst aid actors was also cited by Alliance members.

2.4.4 Funding Sources in the Future

The favoured modalities for DC by our politicians. They may change. They may look at other modalities of cooperation that exclude the fairly time consuming and small project approach that comes under ESTHER umbrella.
Northern Government Representative

There was widespread agreement that for the foreseeable future bilateral aid was likely to be in decline. Whilst this was seen as being a threat to institutional partnerships it was also seen as an opportunity in terms of advocating for institutional partnerships as a low cost form of development cooperation. The reduction or removal of bilateral funding for partnerships programmes was also seen by some as a catalyst for finding other ways to engage. This has been the case for Greece which is now focussing on the potential of developing partnerships between Greek hospitals and the existing network of Greek FBO hospitals in Africa. Switzerland and Ireland are seeking ways to catalyse partnerships rather than fund them.

There was broad agreement that success in accessing external funding was central to the sustainability of the work of the ESTHER initiative. Funding sources for partnership working identified by the members included:

- Southern country-based unspent aid allocations;
- Southern country-based donor funds;
- EC grants and service contracts;
- Research funding;
- Multilaterals (GFATM, UNITAID etc);
- INGOs;
- Private foundation funding.

I think if we position ourselves as an organisation that depends on public funding to be able to operate we will do ourselves a disavour in terms of securing something long-term.
Northern Government Representative

2.4.5 Need to demonstrate effectiveness

The benefits are quite hard to quantify and pin down. Evidence is crucial. Benefits to the north and to the south need to be pinned down.
Northern Government Representative

There was widespread agreement that one of the key steps to providing sustainability to institutional partnerships as a recognised form of development cooperation was the need to demonstrate effectiveness. Members were acutely aware that being able to prove that quality partnerships had a real impact in the north and in the south and that the Alliance members were able to foster quality partnerships was a crucial step in being able to sell the model and the Alliance to funders and politicians.

2.4.6 Enlargement

If we can continue to enlarge the network it can have a leverage effect for those who are already members whose programmes are weak can see it is growing and becoming interesting and they can then think again about their involvement and capacity to be involved.
Coordinating Body Representative

Whilst more than one country talked about enlargement of the number of country members within the Alliance as a key indicator of the Alliance's future success, within the interviews there was little discussion regarding the need for new members. Rather the preoccupation and priorities for members was to attain a common strategy and move towards joint projects.

2.4.7 Analysis and Recommendations

The broadening of the mandate is good - creates opportunities but on the other hand there are too many actors and donor funding is coming down. The way to go is to find a unique niche in terms of expertise that no one else has and this would be a sustainable health initiative.
Northern Government Representative

For ESTHER to be an effective actor within the development cooperation landscape it needs to fill a niche that is not covered by other agencies, thus avoiding the negative effects of aid proliferation and fragmentation. There are a number of areas within which ESTHER could have a unique offer within the development cooperation landscape through the medium of peer-to-peer partnerships in health. These are:

- Institutional strengthening of key national and regional health institutions including hospitals;
- Strengthening medical education and continual professional development for healthcare personnel;

- Quality improvement of service delivery in the health sector, based on promoting the adaptation and use of known, evidence-based interventions;
- Building capacity in operational and implementation research;
- Building capacity in the treatment, prevention and management of non-communicable diseases.

Peer to peer partnership between health services in the north and south are particularly well positioned to provide expertise in these areas, which is otherwise hard to access.

Contributing to medical education and continued professional development is fundamental to addressing the human resource crisis in lower and middle-income countries. This area is one which after much lobbying is now receiving much needed attention and funding from both donors and governments. It is also an area where developments in ICT are enabling relatively low amounts of funding to have a significant impact on the availability of high quality education services across wide geographical areas (examples include the work of ESTHER Spain and the COSECSA-RCSI partnership under ESTHER Ireland). It is also an area where the collaboration of ESTHER members on supporting regional institutions could be an area of fruitful collaboration resulting in lasting impact.

NCDs are increasing in importance in terms of the burden of disease in low and middle income countries. However, the majority of funding is still focussed on communicable diseases, though there is enough discussion within the global health community for it to be relatively certain that funding will follow in the future. ESTHER has a particularly unique offer in this area as most of the non-communicable disease expertise lies within the health services of northern countries. There is a real opportunity to position ESTHER as a major contributor in this nascent area of development cooperation. It is recommended that knowledge generation, case studies and networking are focussed in this area by the EEA and those members interested in pursuing work in this focus area.

In addition exploring how health partnerships could add value to the universal health coverage agenda and exploring how to ensure that partnerships work with a health systems strengthening approach are potentially important themes for ESTHER to develop in the future.

In the context of the economic crisis and the growing results based management agenda it is crucial that ESTHER can demonstrate the effectiveness of the partnership model. There is a tension between this imperative and the need of the volunteer implementing partners for “light touch” M&E and oversight. Undertaking funded research that seeks to add to the evidence base rather than requiring implementing partners to undertake more rigorous and complex M&E in challenging circumstances may be one way to meet donor needs without overburdening implementers.

ESTHER also needs to show that it has considered, and has created solutions, to some of the main concerns raised by donors regarding utilising partnerships as the vehicle for technical assistance. Not all of these concerns are relevant to every model of partnership working. Concerns that have been raised include:

- ensuring that partnerships are southern led and aligned with national strategies and plans;
- ensuring that partnerships do not contribute to aid fragmentation and burdens to host organisations through project proliferation;
- ensuring that partnerships are strategic and adhere to best practice in development cooperation;
- ensuring that good practice and tools are communicated and disseminated;
- how to create impact and synergy through partnership work.

Key Recommendations

1. Explore the level of interest among EEA members to work in areas of emerging importance in the development cooperation landscape within which institutional partnerships can fulfil a niche role. These may include:
 - a. Institutional strengthening of key national and regional health institutions including hospitals;
 - b. Strengthening medical education and continual professional development for healthcare personnel;
 - c. Quality improvement of service delivery in the health sector, based on promoting the adaptation and use of known, evidence-based interventions;
 - d. Building capacity in operational and implementation research;
 - e. Building capacity in the treatment, prevention and management of non-communicable diseases;
 - f. Contributing to universal health coverage.

SECTION 3: BILATERAL PARTNERSHIP PROGRAMMES

This section of the report seeks to explore some of the commonalities and challenges faced by the varied bilateral partnership programmes within the framework of relevance, efficiency, effectiveness, impact and sustainability. It also exemplifies best practices of the EEA members. The analysis and recommendations section then seeks to develop understanding about the different modalities of partnership programmes and the potential they have to impact on health systems.

3.1: RELEVANCE

3.1.1 Political Commitment

That political foundation is why the commitment is carried over from one year to another in terms of financial resources being set aside for this programme. Northern Government Representative

The level of political commitment towards bilateral partnership programmes varied widely between member countries. For some countries there was a high level of political commitment that was accompanied by significant funding (for example France) for others despite political commitment, funding had been minimal (for example Switzerland and Ireland). Both the economic crisis and changing political priorities in development cooperation were seen as potential threats to future funding of bilateral programmes at the national level. A number of countries expressed their frustration at the lack of government participation and funding and talked about the need to generate more attention and visibility for the approach amongst politicians for whom it was not currently seen as a priority. Establishing an evidence base on the effectiveness of the approach was seen as a key step to increase visibility of the model amongst politicians.

Not all countries had the necessary level of support from Ministries for the programmes to maximise their effectiveness. For others the hospital partnerships programmes were creating opportunities for cross ministry working that was seen as innovative and a model for the future. Whilst many members felt that the programme needed the support of the ministries involved both in health and in development cooperation to be effective - some countries identified other ministries they would like to involve in order to be able to move forward on certain activities (for example the Ministry of Science in Germany which is responsible for research).

For some member countries the political organisation of the health service makes coordination of partnerships on a national basis challenging since hospitals are not under national authority but under forms of decentralised authority (for example Switzerland and Germany). Whilst this type of organisation does not preclude participation in hospital partnerships it does create additional challenges for coordination, funding and the creation of an enabling environment for voluntary work.

It rests on the initial political commitment but it is not driven or asked for very much by the political leadership as much as before. Northern Government Representative

3.1.2 Alignment with Northern Government Priorities

Bilateral programmes were perceived to be aligned with national development cooperation priorities. However, a common challenge faced by many of the bilateral programmes was that hospital management often did not see international development cooperation as a priority activity. The reduced budgets and constraints faced by many northern health services have compounded the pressure on staff to account for their time, providing services to patients of their hospitals in the north rather than committing time to overseas partnerships. However, most coordinating bodies felt that there was still a significant untapped resource of health workers in the north who were motivated to cooperate in institutional partnerships with countries in the

south. In addition where hospital partnerships already existed, these were not necessarily within government priority countries. However where such partnerships have already been built, these were seen as valuable partnerships which should continue to be supported.

3.1.3 Alignment with Southern Government Priorities

At the point of twinning we were asking them to do a baseline survey for each of them so that at some point we could have a mid-term review and we see whether or not they are going in the right direction and then at the end whether it has achieved something and if not why not. Other people can then learn from the experience. You need resources to do that type of work. Southern Government Representative

The bilateral programmes had different methods of seeking to align partnerships with southern government priorities. Some bilateral partnership programmes were designed hand in hand with southern governments and partnership stakeholders in the south (for example France and Spain). Other bilateral programmes made alignment a requirement of their criteria for funding but the process was left to the individual partnerships (for example Norway and UK). Germany has a model of seeking to support partnerships that complement other development cooperation in health which they are already have in place.

National alignment with Ministry of Health plans and strategies was seen as crucial but it also needed to be done in a way that was not burdensome on southern governments.

For southern government representatives' partnership was seen as an important tool for improving health services and systems but there were challenges in being able to keep track of partnership initiatives and ensure that best practices and learning arising from the projects was shared. One southern government representative stated that they needed a full time post to keep track of these type of initiatives and to ensure that their results had the right level of visibility and impact within the Ministry of Health - currently it was one duty within an already burdensome level of responsibilities. The representatives interviewed in Ghana and Uganda were not aware of the ESTHER partnerships or brand, however, they were aware of other partnership initiatives within health in their country and oversight of such programmes was within their remit. In contrast, the Burundian southern government representative was highly engaged in the ESTHER programme.

We need the information at national level - anybody who comes to work in the country needs to tell me as I am the one in charge of providing the service - I have to document services done externally or internally for the annual report. I need to document the work that is being done between partners working with our local people. Southern Government Representative

3.2: EFFICIENCY

3.2.1 Resourcing

When you do not have a lot of money you have to think more and take advantage from other opportunities. Coordinating Body Representative

The level of financial and human resources available to the coordinating bodies varied widely. France and the UK have the largest amount of funding and number of staff who are focussed on partnership programmes. For the majority of the coordinating bodies, partnership programmes are just one part of their portfolio of work and responsibility. There were a significant number of the coordinating bodies who had limited human resource available to sustain or initiate bilateral partnerships programmes.

The lack of bilateral funds for projects for both some of the newest members and those hardest hit by the economic crisis was showing some evidence of stimulating innovative ways to promote partnership working.

Greece is exploring the possibility of remote partnerships between hospitals in Greece and the significant network of Greek faith-based hospitals in Africa. Ireland and Switzerland are looking at ways to catalyse partnerships and promote best practice without providing partnership funding. One interviewee outlined that there are pros and cons in providing funding to partnerships - on the positive side it enables partnerships to undertake quality projects together but on the negative side it can negatively affect ownership and commitment as the focus is shifted to meeting funding criteria. However, self financing partnerships require a high level of commitment.

3.2.2 Role of the Coordinating Body

If northern implementing partners go off and do their own projects which are not accountable, not talking to anyone, it does not work and it is not good for the world and it is not good for them - so we think it is better to bring people together and sign up to principles, share information and undergo evaluation.

Coordinating Body Representative

The level of resourcing of the individual coordinating bodies and the type and scale of their partnership programmes also affects the level of support they give to their implementing partners. The types of support provided to implementing partners included:

- Promotion of partnership model;
- Promoting best practice;
- Collaborative design and planning of projects;
- Management of overall programme of work for partners;
- In country staff to support implementation, reporting and M&E;
- Orientation in working in low and middle income countries;
- Training and guidance in project planning, needs assessment, management and M&E;
- Training and guidance in development cooperation and global health;
- Organising events to share learning;
- Monitoring the quality of partnerships;
- Problem solving.

The French model involves a very collaborative implementation of partnerships with ESTHER France. Project managers have oversight of all partnerships in a particular country/region and are highly engaged in the work - providing mentoring in project management and development cooperation. National coordinators are also appointed to assist in implementation, problem solving, communication, reporting and M&E. This model of support, however, is only viable with significant national funding at a level which is not the norm for most of the EEA members.

Spain has had a radically different model to that of most of the other bilateral programmes and has developed a health professional network, working with secondary and tertiary level hospitals to promote knowledge exchange. Activities include in-country training workshops with partner hospitals, study visits to Spain and an online masters programme. The partnership is between the Spanish government and the Ministries of Health in their partner countries. Volunteer professionals who undertake the work are sourced from hospitals across the different regions of Spain. The Spanish ESTHER coordinates the work, working closely with the Ministries of Health in the south and the volunteer health professionals.

Norway is a proponent of longer-term (6-18 months) exchanges of personnel within their partnership programme. FK Norway already had long experience of promoting exchange of young people for development cooperation and their ESTHER programme was designed to follow a similar methodology. Whilst these long term exchanges are seen as having a lasting impact and value to those that have undertaken them, it has been challenging to adapt the exchange model to fit with the requirements of professionals within the health sector.

Germany is seeking to find ways to align their health partnerships much more with other health programmes that are funded bilaterally - seeking not only to create synergy but also to be able to provide more technical support to the partnerships and have in country resources that can monitor their progress.

The UK puts out calls for proposals for funding of health partnerships whilst in Norway partners can apply for funding at any time through the year. Norway requires mutual exchange visits between the north and south in each direction. The UK fund partnerships to different levels depending on the partnerships age and the size of the project they wish to undertake collaboratively. Funding criteria include alignment and equal ownership. The relationship between the coordinating body and the implementing bodies is one of funder. The amount of additional support given to the partnerships varies between the coordinating bodies but also with the requirements of the individual partnership.

The UK has developed some excellent resources on best practice in partnership working. Many of the coordinating bodies organise training and regular sharing events for implementing partners in the north.

3.2.3 Availability of Northern Volunteers

Partnerships need an enabling environment for them to thrive and evolve and other partnerships to emerge. Removing barriers to volunteering but also selling the concept to hospital management - getting them to understand what it is in it for them. Coordinating Body Representative

Whilst most members identified that there was a significant pool of health service professionals with an interest in being involved in development cooperation there were emerging fears of taking resources away from critical services in the north. This was particularly acute in countries where there was a perception that health services in the north were stretched. Increased monitoring of the way in which health service personnel utilised their time was also a potential threat to the availability of volunteers. The amount of time that health service volunteers were able to commit to partnerships and whether or not that was paid time or personal time varied widely between not only member countries but also individual institutions. Decisions about how much time could be released was often one for the hospital management and hence ensuring that hospital administrations were part of the partnership was seen as a critical success factor.

In the UK there has been work done to produce national guidelines for hospitals promoting the idea of partnership working and outlining good practice in the release of staff. France conducted a costing activity in 2011 and showed that the cost to the hospital of participating in a partnership programme was minimal in comparison to their operating budget.

For some countries hospital staff may not be on long term contracts unless they are on an academic track (for example Switzerland) and other members referred to it being easier to access volunteers from university hospitals as they often had greater flexibility.

The long term volunteering promoted by Norway has its distinctive challenge in terms of access to volunteers and the level of remuneration that they receive whilst on exchange. This is primarily a challenge for northern implementing partners.

3.3: EFFECTIVENESS

A comparative analysis of the effectiveness of the bilateral programmes was beyond the scope of this study. We have, however, drawn out common themes and examples of good practice from the interviews and documentation provided by EEA members.

3.3.1 Approach

The detail of how you do things is important

Northern Government Representative

Members agreed that quality partnerships had a very positive effect if based on a development approach. The core of a partnership approach is that it is of benefit to both sides.

Factors that prevented partnerships attaining optimum effectiveness included:

- Mismatched expectations between partners.
- Substitution approach rather than a development approach.
- Opportunistic rather than strategic partnerships (either through chasing funding or on the basis of personal links rather than identifying strategic institutions)
- Paternalistic attitude from north.
- Implementation of solutions from the north without adapting to local context.
- Lack of sufficient people involved in the partnership - threat of failure if staff move on.

One interviewee spoke of the importance of remembering that people were at the heart of the partnership.

One southern implementing partner stated how important it was for them that they received their funding directly rather than via the northern implementing partner as it laid a good foundation for equality between the partners and also was an efficient route for the funding to flow.

Some members noted that their approach had evolved as they learned from experience what worked best. This included not simply transplanting solutions from the north to the south and also moving from a site-to-site approach to a more programmatic approach in partnership with southern government programmes and institutions.

Members also stated the importance of building learning into the approach. This was also reflective of the process that partnerships learn over time as they learn from experience and build trust. Training by the coordinating bodies was also cited as having resulted in noticeable improvements in funding applications and reporting. Peer review was identified as a valuable tool for learning and quality assurance.

Twinning and working together is better than technical assistance providing advice. Partners are open to learning and can share a lot of things within the working environment.

Southern Government Representative

3.3.2 Scale and Focus

The number, size and geographical distribution of members bilateral programmes show a very wide distribution, with a specific challenge to increase visibility of projects when they were small scale and/or widely distributed. Some of the members remained very focussed on HIV/AIDS - the original motivator for the ESTHER model. Others had a much wider thematic focus which enabled them to work in areas often neglected by development cooperation. Those bilateral programmes with a narrow thematic focus and which also adopted a more programmatic approach had stronger engagement and alignment with southern governments for example France and Spain.

3.3.3 Capacity of Volunteers in Development Cooperation

Someone who comes should understand how the systems work here. If someone is coming from Europe without that knowledge then they have to learn and they are not conversant. Cannot bring something from Europe and implant it here - it does not work. In twinning there must be learning from both sides.

Southern Government Representative

Members agreed that developing the understanding of northern health service professionals in best practices and thinking in development cooperation was an important role for the coordinating body. Whilst some volunteers from the north had experience of working in low and middle income countries, others did not and benefited from orientation in development cooperation and in particular the importance of alignment and a health systems approaches. In addition, practical skills in partnership best practice, on site supervision, communication, capacity building, and M&E or results based management were also seen as useful.

Germany conducts training workshops with their northern implementing partners that mix workshops with the opportunity to work through learning on their own particular partnership.

Implementing partners interviewed appreciated support given but preferred flexible and bespoke support to compulsory training.

The doctors have their own language and development experts have their own language but I think it matches well with the health experts speaking to the health experts and leaving the development language outside.

Northern Government Representative

3.3.4 Difficulty of Demonstrating Results

The cry for results is increasing nationally and across Europe.

Northern Government Representative

The need, yet difficulty of demonstrating the effectiveness of partnerships was a common issue for EEA members. The difficulty of measuring capacity development programmes in Africa is not one which is specific to the partnership model. But members recognised that there is a need to justify the use of resources to current or new funders and hence this was a challenge that needed to be met. The lack of experience and understanding of the results agenda amongst implementing partners was also cited as an additional barrier.

It is not something you can just count. That is the challenge and to have decision makers understand - we have to describe that some strength has been built or supported that is crucial for the objectives that the partners in the south are seeking to achieve.

Northern Government Representative

3.4: IMPACT

3.4.1 Scale

In terms of impact members outlined some of the advantages and disadvantages of small and large scale partnerships. The following table summarises some of these points for the two extremes of the continuum of scale.

	Small Scale	Large Scale
Example	Site-to-site	Programmatic
Potential Advantages	<ul style="list-style-type: none"> • Management scale for volunteers • Retain personal relationships • Can mobilise on the basis of personal commitment 	<ul style="list-style-type: none"> • Easier to align with national programmes and institutions • Can effect health system/more easily go to scale
Potential Disadvantages	<ul style="list-style-type: none"> • Need to advocate for scale up to have impact beyond the institutional • Threat of distortion of the health system <ul style="list-style-type: none"> - pockets of excellence become overwhelmed by demand • Danger of only localised change 	<ul style="list-style-type: none"> • Lose personal relationships • Only larger organisations can manage large partnerships

One interviewee stated that it would be interesting to compare the benefits and impact of larger partnerships versus site-to-site partnerships.

3.4.2 Health Systems Strengthening

You cannot achieve and have important outcomes without health systems strengthening.
Coordinating Body Representative

Examples of reported health system strengthening arising from health partnerships included:

The ESTHER France approach is implemented hand in hand with the Ministry of Health in implementing countries and is akin to a programme approach delivered through the medium of hospital partnerships. Hence it has been able to contribute to national policy development, contribute to national programmes as well as conducting experimental projects that can then influence future policy areas. In 2012 in Burundi, ESTHER France partnerships have trained 1200 medical, paramedical and technical staff and have strengthened the links between patient associations, community-based organizations and health institutions in order to better respond to the needs of HIV/AIDS patients.

The project has been useful at the national level, especially with respect to training. For example, with the Inter University Diploma program, we've trained many people from the health facilities from the interior of the country who then return to their home facilities and that contributes to the decentralization of HIV treatment and care.
Burundian Government Representative

In the German bilateral programme results of partnership work are now impacting beyond individual sites. One hospital stated how it is hosting training seminars in quality improvement methodology with participants coming from other hospital in Tanzania and from the East and Southern African Region. There is also evidence that this work is influencing national level policy. National Level is reviewing the quality improvement tools and methods developed in this project (client exit interviews, algorithms and SOPs) for possible scale-up to other referral hospitals in the country.

The work ESTHER Spain has developed across Central and South America has contributed to health systems strengthening at several levels. On one level more than 530 clinicians have been awarded Masters Degrees in HIV infection, greatly building the medical health workforce within Central and Southern America to prevent, diagnose and treat HIV/AIDS. Prior to Spain's support it was very difficult for medical doctors to receive specialist training in HIV, unless they left their country. The success of this programme has resulted in influencing national policy and practice through the development of new programmes and treatment.

Originally there were only 2 hospitals that were able to treat HIV. I can see real change as the result of this work. At national level we contributed to the development of National HIV guidelines and now there is a PMTCT Programme in the country.

Southern Implementing partner

The COSECSA-RCSI partnership under ESTHER Ireland and the Prosthetic and Orthotics Capacity Building partnership under ESTHER Norway are both examples of how the strategic choice of a partner organisation extends the reach of the capacity building beyond a localised area. Both these partnerships are with key regional training institutions that cover a large number of countries in underinvested but important areas of medical practice.

The WHO African Partnerships for Patient Safety (APPS) initiative is an example of how hospital partnerships can become communities of practice with tools and frameworks that can be shared allowing spread beyond the initial partnership sites.

I think there is a potential that results can be used to influence the health system as a whole but it is a question of resource about being visible and communicating the results.

Coordinating Body Representative

3.4.3 Value for Money

In terms of money it is nothing compared to what we usually do.

Northern Government Representative

Members felt that health partnerships were good value for money and that resources were very efficiently used in this form of development cooperation.

3.5: SUSTAINABILITY

In order to be relevant we need to respond to new needs - move towards health promotion and prevention.

Coordinating Body Representative

The changing priorities of politicians was seen as both a threat and an opportunity for future bilateral partnership programmes. A threat due to changing priorities and preferences for other modalities but an opportunity due to its low cost. A key message from many members, however, was that the health partnership movement needed to demonstrate its efficacy, efficiency and impact to sustain or build funding in the future.

Many of the health partnership programmes that had been funded by their national governments were facing budget cuts in the future and so were keen to explore other routes of obtaining funding for partnership work.

As previously discussed the changing priorities in global health also provided many areas where institutional partnerships could fulfil an important niche.

3.6: ANALYSIS AND RECOMMENDATIONS

We are in daily contact with the MOH - they are well integrated. It also depends on the model you implement. You can have a hospital partnership and run it like an NGO - the MOH do not even know you are there.

Coordinating Body Representative

Alignment with southern governments and the visibility of successful partnerships and their learning within the south remains a challenge to some of the bilateral programmes - this is a weakness. It is recommended that the EEA members should focus on developing their models in terms of southern alignment and visibility and as

previously discussed to look at the role of health partnerships within health systems strengthening. In speaking to implementing partners and coordinating bodies it was clear that many of the smaller scale partnerships were not designed in terms of health systems strengthening thus opportunities for health systems strengthening were not capitalised on. When small-scale partnerships had impact beyond their institution this was often due to personal contacts rather than design. For coordinating bodies with small scale geographically widespread partnerships opportunities should be sought to look at existing fora and routes to engage with the MOH on behalf of the partnerships (for example through country donor officials or via annual national hospital conferences).

Whilst the partnership model seems to be accepted as one offering value for money, this is mainly due to the willingness and energy of individuals who are often contributing significant time outside their normal working hours on top of demanding jobs. Hence care must be taken not to overburden these individuals in terms of administration and reporting. It is also recommended that opportunities are sought to celebrate their contribution.

There are lots of examples of best practices amongst the bilateral programmes and hence there is a much potential for learning between the members. In particular the training and support materials that are developed for the purpose of encouraging implementing partners to develop quality partnerships based on best practice would seem a fruitful area for greater sharing and collaboration.

The different models used by the EEA members in their bilateral programmes have different strengths and weaknesses. This report seeks to conceptualise them in order to develop understanding of the different requirements and roles of the models within development cooperation.

If we differentiate the coordinating bodies by the level of support that they are able to give to implementing partnerships and the level of funding that they provide to those partnerships we can see four roles for the coordinating bodies - see Figure 3.

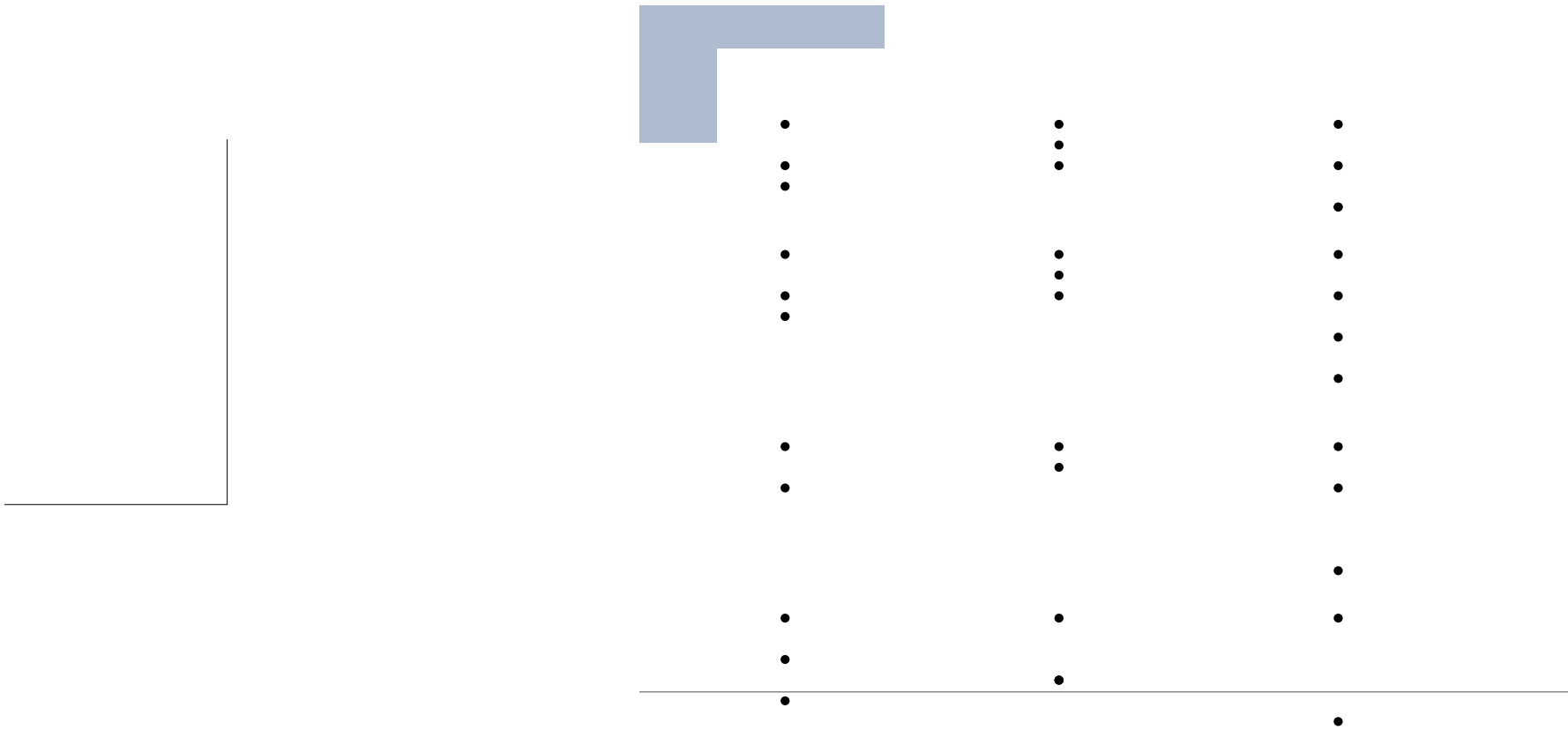


Figure 3 Categorisation of coordinating bodies by level of support and funding provided

If we look at the scale of the partnership programmes (number and size of partnerships) and the thematic focus we can see different potentials for the programmes in terms of influence on health services and systems - see Figure 4.

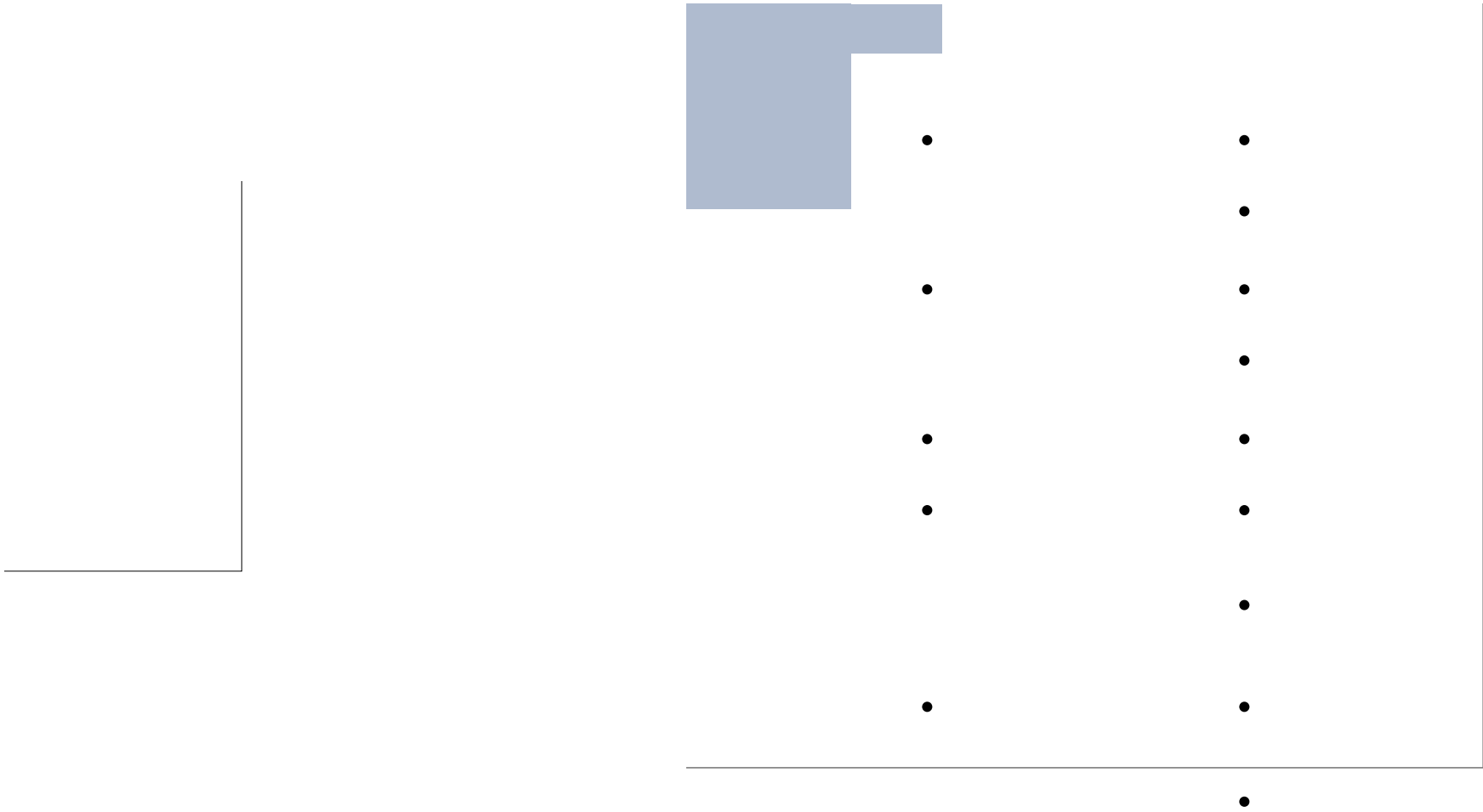


Figure 4 Categorisation of partnership programmes by scale and thematic focus

These frameworks allow us to understand the differentiated role that it is possible for small scale partnership programmes to have. The full impact of the approach, however, will only be attainable if the programme is designed to take advantage of the opportunities that the approach has to influence health systems. For example if successful innovations are not communicated then they are unlikely to have anything more than localised impact. Hence finding routes where best practices, learning and tools can be shared is of crucial importance in maximising the impact of health partnerships.

Recommendations

1. It is recommended that bilateral partnership programmes ensure that their partnerships have the appropriate level of engagement with the Ministry of Health according to their scale and focus.

SECTION 4: CASE STUDIES KEY LESSONS LEARNED

Some of the key themes from the implementing partners who completed interviews and pre-interview questionnaires are summarised in the following table.

Enablers	Barriers
<ul style="list-style-type: none"> • Ownership and commitment to partnership from institutional leaders • Southern leadership and northern facilitation • Vision of team leaders • Support from management • Following international guidelines • Making links with national programmes • Making links with strategic national institutions • Working alongside other bilateral initiatives • Familiarity with partners • Common objectives • Dedication and commitment of staff • Regular planning and reviews • Collective planning and decision making • Strong technical skills • Empowerment through capacity building • Accessibility of northern volunteers • Desire to learn from colleagues in the south • Sufficient project budget • Funder that appreciates the value of incremental institutional change • Cooperation between northern partners and division of work • Stipends for Southern partner project staff to supplement their low salary and increase motivation 	<ul style="list-style-type: none"> • Lack of commitment from institution and/or staff • Ensuring that hospital staff and management understood project aims and processes • Lack of capacity in project management, finances and administration • Infrastructural problems - electricity supply, internet access... • Resistance to change • Failure of communication • Development of M&E tools • Time constraints • Time consuming reporting procedures • Low salary levels for long term volunteers • Lack of flexibility in timing of preparatory courses • Lack of responsiveness from partner institutions • Need to develop cultural sensitivity and awareness amongst some volunteers • Culture shock • Lack of funding coming directly to southern partners • Lack of sufficient funding for project management, administration and financial management • Managing the allocation of project funds between partners and individuals • Shortage of budget • Lack of continuation of funding • Frequent management changes and difficulty maintaining continuity of programs • Ensuring sustainability • Language barriers

Lessons Learned

- Turn partnerships from personal links to institutional links
- Project must be anchored in top level of administration
- Takes time for partners to move from an expectation of gain from a project to understanding what it means to be an equal partner who contributes as well as receiving benefits
- Ensure that leadership are committed to the partnership
- South-south collaboration is convincing - what works in one part of the south can work elsewhere
- Together we can move far, alone I can move fast - need for team work
- Involvement of national institutions is crucial to sustainability of activities
- Focus more - less activities and indicators
- Set clear, timely objectives and indicators
- Need better time management for project activities
- Importance of timely and reliable communication
- Investing in induction improves effectiveness
- Ensure that expectations are appropriate to the skills levels of volunteers - junior versus senior staff
- Experiences of working with patients in the same disease area can be very different in different contexts
- Do a baseline survey so that the project can be evaluated properly
- Be realistic about what results it is possible to achieve
- Northern benchmarks are intimidating for southern partners
- Look at how to develop capacity in project management, financial management and administration
- Importance of operational funding
- Clear division of work between partner institutes is important
- Important to focus on a few objectives and do them very well, rather than trying to take on too much
- Importance of integrating the partnership into the regular operation of the Southern institute
- Importance of diversifying funding sources
- Flexibility in adapting objectives within multi-partner partnerships

CONCLUSIONS AND KEY RECOMMENDATIONS

FROM FAITH TO SCIENCE - INSTITUTIONAL PARTNERSHIPS AND HEALTH SYSTEMS

There is a need for the partnership model to move from faith to science. To date much of the funding for partnership initiatives has been on the basis of a belief that this form of working is effective and cost effective. The partnership movement needs to understand why interventions work and underpin this with a robust evidence base. This would form a key foundation from which to advocate and bid for new funding within a results-based agenda. This evidence base will enable bilateral programmes to make robust arguments for continued funding and form the basis of proposals for external funding.

CREATING ADDED VALUE - THE ROLE OF THE EUROPEAN ESTHER ALLIANCE

Four key areas have been identified in which the Alliance could create added value beyond what is possible for the bilateral programmes. The work of the Alliance itself should be differentiated from the bilateral partnership programmes of the membership - focussing on the areas where it can add value whilst allowing the diversity of approaches to enrich and generate new knowledge. The resulting overarching vision would enable the Alliance to decide on a strategic set of actions to achieve the agreed objectives. It will also inform what type of structure and membership will best support the strategic framework.

Suggested aims for the European ESTHER Alliance are:

An alliance that brings together European governments and their institutions to develop capacity in service delivery and operational/implementation research, through institutional partnerships that strengthen health systems and improve health outcomes. The Alliance has four aims:

1. To generate knowledge and learning on institutional partnerships in global health.
2. To advocate for institutional partnerships to be recognised as a valid form of IDC, which strengthens the overall response to global health problems.
3. To create an enabling environment for joint programmes of work between its members.
4. To promote the adherence of current best practices within ESTHER partnerships.

POSITIONING WITH DEVELOPMENT COOPERATION LANDSCAPE

If ESTHER effectively positions itself as a niche actor within the emerging post-MDG agenda and underpins its work with a robust evidence base and body of best practice, ESTHER could undoubtedly add value to the development cooperation landscape.

Key areas of focus include:

- a. Institutional strengthening of key national and regional health institutions including hospitals;
- b. Strengthening medical education and continual professional development for healthcare personnel;
- c. Quality improvement of service delivery in the health sector, based on promoting the adaptation and implementation of known, evidence-based interventions;
- d. Building capacity in operational and implementation research;
- e. Building capacity in the treatment, prevention and management of non-communicable diseases;
- f. Contributing to universal health coverage.

KEY RECOMMENDATIONS

1. EEA should agree a common terminology for partnership working that encompasses partnerships beyond hospitals.
2. EEA should recognise that within their existing partnerships they contribute to Health Systems Strengthening and performance at different levels (institutional, district/regional and national level). There is a need to articulate more clearly the theory of change as to how these levels contribute to health systems strengthening which can then underpin the development of a more robust evidence base.
3. Further work on the conceptualisation of the added value of health partnerships is required paying particular attention to donor concerns. This can form the basis of a joint research strategy to seek funded research proposals that underpin the case for health partnerships as a valid form of development cooperation.
4. Commissioning value for money studies on the EEA's different partnership models of working would allow ESTHER to demonstrate to donors and other funding bodies the impact and cost of existing programmes.
5. The members of the EEA should conduct a visioning workshop based around the four added value themes from this evaluation, which should lead to the development of an Alliance strategic vision and plan for the next 5-years.
6. Once agreement has been reached on the core areas of focus for the Alliance, working groups should be established that mirror these agreed strategic objectives (ideally no more than four).
7. Working groups should establish an operational plan for the coming year and a 5-year strategic plan which includes key milestones and indicators against which progress and success of the Alliance can be measured.
8. In the medium term members will need to make a financial and time commitment to the Alliance to enable it to deliver and develop.
9. Applications for joint external funding (research, knowledge hubs, programmes) should include a costed coordination role for the EEA Secretariat contributing to its future income streams.
10. In the longer term, consideration could be given to expanding the membership base to include 'Institutional Members' who align with EEA strategy.
11. Develop a knowledge management and generation strategy that focuses resources on applying for funded research that underpins the case for institutional partnerships as development cooperation.
12. Form a working group on external funding which is initially focussed on creating an enabling environment for joint funding.
13. Review the website content in the light of the visibility document and move from seeking to have complete listings of partnerships to featuring case studies of successful partnerships.
14. An annual case study competition could be held for implementing partners to write up their experiences as case studies - a financial prize to the partnership would add an incentive and would have relatively little cost if all active members contribute to it.
15. Further simplify the aggregate information that is gathered at EEA level.
16. Explore the level of interest among EEA members to work in areas of emerging importance in the development cooperation landscape within which institutional partnerships can fulfil a niche role.
17. It is recommended that bilateral partnership programmes ensure that their partnerships have the appropriate level of engagement with the Ministry of Health according to their scale and focus.

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ANNEX 1: LIST OF INTERVIEWEES

EEA Secretariat n = 1

Farid Lamara, EEA Secretariat

Northern Government Representatives n = 9

France: Dr Gustavo Gonzalez-Canali, General Directorate for Globalisation, Development and Partnership, Ministry of Foreign Affairs

France: Brigitte Arthur, Ministry of Health and Social Affairs

Germany: Raphael Teck, BMZ

Ireland: Dr Diamuid McClean, Irish Aid

Italy: Dr Fabrizio Oleari, Ministry of Health

Luxembourg: Natascha Gomes, Ministere des Affaires Etrangeres, Direction de la Cooperation au Developpement

Norway: Bjarne Garden, Dept for Global Health, Education and Research, NORAD

Spain: Amanda Gil Sanchez, Ministry of Health, Social Services and Equality

Switzerland: Andreas Loebell, DEZA

ESTHER Coordinating Body Representatives n = 11

France: Dr Gilles Raguin, GIP ESTHER France

France: Professor Dominique Israel-Biet, Chair of GIP ESTHER France

Germany: Michael Beyer, Division of Health, Education, Social Protection, GIZ

Germany: Dr Brigette Jordan-Harder, GIZ

Greece: Dr Chrysoula Botsi, KEELPNO

Ireland: Dr David Weakliam, HSE-DOH

Italy: Stefano Vella MD, Department of Pharmacology, ISS

Norway: Ingunn Gihle, FK Norway/Fredskorpset

Spain: Dra Rosa Polo, National Aid Strategy Secretariat, Ministry of Health, Social Policy and Equality

Spain: Dra Inmaculada Gisbert Civera, PAHO, Washington

Switzerland: Dr Nathalie Mezger, Hopitaux Universitaires de Geneve (HUG)

Observer Status Representatives n = 3

UK: Sue Chandler, Department for International Development

UK: Andrew Jones and Rachel Schofield, THET

Southern Government Representatives n = 3

Ghana: Dr Frank Nyonator, Ministerial Adviser on Health Systems Strengthening, Director, Human Resources for Health Directorate, MOH

Uganda: Dr Jackson Amone, Assistant Commissioner, Integrated Curative Services, Ministry of Health

Burundi: Dr. Rirangira

Northern Implementing Partners n = 9

ESTHER FRANCE

Burundi partnership: Dr Arvieux Cedric, Infectiologue au CHU de Rennes/France

Laos Partnership: Pr Patrick Yeni, Coordinateur du projet, hopital Bichat

Niger Partnership: Pr Elisabeth Rouveix, Coordinatrice du Projet Niger

ESTHER GERMANY

Tanzania Partnership: Professor Michael Hoelscher, Director, International Medicine & Public Health, Department for Infectious Diseases & Tropical Medicine, University of Munich, LMU

Malawi Partnership: Dr Florian Neuhann, Institution of Public Health

ESTHER IRELAND

COSECSA Partnership: Eric O'Flynn, Collaboration Programme Manager

ESTHER NORWAY

Prosthetic Capacity Building Partnership: Mr Rune Nilsen, Head of Department

ESTHER SPAIN

Professional Network Masters Programme: Dr Maria Jose Galindo, Faculty of Medicine, University of Valencia

ESTHER ITALY

Ethiopia Partnership: Raffaella Bucciardini, Insitituto Superiore di Sanita

Southern Implementing Partners n = 11

ESTHER FRANCE

Burundi Partnership: Dr Jean-Bosco Nduwarugira, Directuer General

Laos Partnership: Dr Phanomxay Phakan, Luang Prabang Provincial Hospital

ESTHER GERMANY

SSN Partnership: Dr Charles Awasom, Director of Bamenda Regional Hospital

SSN Partnership: Dr Adam Lyatuu, Hospital Administrator Bombo Regional Hospital

Tanzania Partnership: Dr E Samky, Director Mbeya Referral Hospital

ESTHER IRELAND

COSECSA Partnership: Professor Krikor Erzingatsian, Registrar/CEO

COSECSA Partnership: Dr Abebe Bekele, Ethiopian Country Representative

ESTHER ITALY

Ethiopia Partnership: Amanuel Haile, Director of Ayder Hospital

ESTHER NORWAY

Prosthetic Capacity Building Partnership: Mrs Kheng Sisary, Country Director

Zanzibar Partnership: Ms Mwanaidi Ali Daudi

ESTHER SPAIN

Professional Network Masters Programme: Dr Greta Mino, Head, Children's Hospital of Guayacil, Ecuador

Other n=2

Shams B Syed, Global Partnerships Lead & APPs Program Manager, WHO

Karen Heard Laureote, University of Portsmouth

ANNEX 2: QUESTION GUIDES

NORTHERN GOVERNMENT REPRESENTATIVES

What do you see as the added value of working through hospital partnerships in comparison with other forms of technical assistance? Do hospital partnership programmes contribute to health systems strengthening?

How would you describe the level of political commitment to hospital partnerships in your country? What factors affect the level of political commitment?

What do you see as the key opportunities and threats to working in hospital partnerships in your country?

What would you like to see change in terms of hospital partnership work in the future?

What do you see as the added value of being part of EEA?

What are the benefits and challenges of the current EEA operational model?

In the future what would success look like and what changes would you like to see for the EEA?

What changes in global health and the international development cooperation landscape do you think might affect the EEA?

ESTHER SECRETARIATS

EUROPEAN LEVEL QUESTIONS:

What do you see as the added value of being part of EEA?

Do you think the EEA has the right operational model at the moment?

What do you see as the major benefits of being a member of EEA?

What do you see as the major challenges of being a member of EEA?

What do you see as the key achievements of the EEA to date and to what extent has it met its planned objectives?

In the future what would success look like and what changes would you like to see for the EEA?

What changes in global health and the international development cooperation landscape do you think might affect the EEA?

NATIONAL LEVEL QUESTIONS:

What do you see as the added value of working through hospital partnerships in comparison with other forms of technical assistance?

How do you ensure that appropriate, efficient and effective technical assistance is provided through your hospital partnership programmes?

What do you see as the major strengths and benefits of your hospital partnership programmes?

What do you see as the major challenges to your hospital partnership programmes?

How do your hospital partnership programmes contribute to health systems strengthening?

What do you see as the key opportunities and threats to working in hospital partnerships in your country?

What would you like to see change in terms of hospital partnership work in the future?

SOUTHERN GOVERNMENT REPRESENTATIVES

Are hospital (or health) partnerships with external institutions part of your national health strategy?

What do you see as the added value of working through hospital partnerships in comparison with other forms of technical assistance?

How do hospital partnerships have the potential to contribute to health systems strengthening?

What are the particular challenges to national level that come from having hospital (or health) partnerships in your country?

(number of partnerships, information flow - prompt about change)

What do you see as the key opportunities for working in hospital (or health) partnerships in your country?

In terms of [specific partnership] what do you see as the main achievements of this partnership?

How useful have the results of the [specific partnership] been to you at national level?

What would you like to see happen next in terms of the [specific partnership]?

CASE STUDY: PRE INTERVIEW DATA COLLECTION FORM

Briefly describe what the partnership/project aimed or aims to achieve.

Describe your particular roles in the partnership.

Were other funders or partners involved in contributing to the overall aims of the project.

What are the key achievements of this project to date.

What do you think is particularly innovative about this partnership or project (themes, activities, methods of working etc..)

Describe the enabling factors that have led to these achievements.

Describe the barriers you met and, if applicable, how you addressed them.

What lessons have you learned as part of this partnership that would be useful to other health partnerships?

Has this project had any impact beyond your institution (please describe)?

Do you see any further potential for how the results and/or outputs of this project could be used or applied elsewhere (describe how)?

How are the achievements gained under this project going to be sustained in the future?

NORTHERN AND SOUTHERN IMPLEMENTING PARTNERS

Why is this partnership important to your institution (and you personally)?

How do you ensure that the project is aligned with both institutional needs and national priorities?

How do you work to ensure equal ownership between the partners?

Discussion of key achievements of the project from case study pre-interview template.

Discussion of innovative aspects of the project from case study pre-interview template.

Discussion of the enablers and barriers from the case study pre-interview template.

How does the national coordinating body support the work of the partnership?

What approaches to capacity building do you use in the project and how do you ensure that they are appropriate to the local context?

(activities, expertise)

Discussion of lessons learned and impact beyond institution from case study pre-interview template

Discussion of sustainability from case study pre-interview template.

ANNEX 3: CONSULTANT TEAM

CAPACITY DEVELOPMENT INTERNATIONAL

When technical assistance is effectively delivered, it builds local ownership and capacity to sustainably deliver improved health outcomes. Capacity Development International works with individuals and institutions to build their potential to effectively deliver technical assistance and transform practice in resource poor settings. Working with donors, ministries, NGOs and academic institutes, CDI provides consultancy, evaluation and training programmes based on best practice and our substantial real-world experience of delivering and managing technical assistance programmes in global health. CDI can:

- Develop and deliver courses on commissioning, management and delivery of TA
- Facilitate the development of TA strategies
- Provide bespoke support to strengthen capacity to deliver technical assistance
- Design quality assurance into TA programmes
- Evaluate international health technical assistance programmes

Our recent work includes the evaluation of the DFID funded International Health Links Funding Scheme from the perspective of partners in Malawi, Uganda and Zambia. The evaluation was not a formal assessment of impact, rather it served to identify challenges, successes and potential barriers that health links face.

Our Values

We aim to demonstrate an ethical and professional approach through:

- Responding to client's needs and expectations
- Enabling local ownership
- Finding best fit solutions
- Developing organisational and individual potential
- Giving value for money
- Challenging ourselves to constantly improve quality
- Enjoying our work

www.capacity-development.com

DHA Communications is an internationally-recognised development and policy communications consultancy, which works to promote access to basic services, engagement with decision making and people-driven change.

Working with major donors and international development agencies and NGOs, DHA designs and delivers research, evaluations and communications support to public sector reform and the effective delivery of development programmes.

Led by former Special Adviser to the Secretary of State for the UK Department for International Development, DHA Communications specialises in delivering communication strategies for health, education and civil society engagement, narrative development for donor programmes, and change campaigns to build alliances for development. Our team comprises journalists, researchers and communication professionals with a wide range of international experience.

We work across the developing world; including across south east Asia and sub Saharan Africa, as well as in the UK and Europe, advising, managing and supporting programmes with technical assistance to build cost-effective, sustainable policy-led implementation of projects and programmes.

Our recent work includes supporting gender-sensitive communications for the Global Alliance for Vaccination and Immunisation (GAVI Alliance); developing the Basic Services Strategy for DFID-Pakistan's £800 million 5-year country programme and; developing the collaborative process and engagement to develop Zimbabwe's National Reproductive Health Policy.

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ANNEX 4: EVALUATION FRAMEWORK

