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Central project evaluation

Improving Primary Health Care Provision, Libya

Project number 2018.1827.7

Evaluation report

On behalf of GIZ by Dr Eva Tezcan (GOPA) and Omar Awidat (GOPA)
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Evaluator/s:
Dr Eva Tezcan, GOPA
Mr Omar Awidat, GOPA

Consulting firm:
GOPA Worldwide Consultants
Hindenburgring 18
61348 Bad Homburg:
T: +49 61729300
E: info@gopa.de
I: www.gopa.de

Coordination and management:
Claudia Kornahrens, GIZ, Head of Section
Benjamin Bräuer, GIZ, Evaluation Manager
Central Project Evaluation Section
GIZ Corporate Unit Evaluation

Responsible:
Martha Gutierrez, GIZ,
Director of Corporate Unit Evaluation

Editing:
International Correspondents in Education (ICE)

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Deutsche Gesellschaft für
Internationale Zusammenarbeit (GIZ) GmbH

Registered offices:
Bonn and Eschborn
Friedrich-Ebert-Allee 32 + 36
53113 Bonn, Germany
T: +49 228 44 60-0
F: +49 228 44 60-17 66
E : evaluierung@giz.de
I : www.giz.de/evaluierung
www.youtube.com/user/GIZonlineTV
https://linkedin.com/company/gizgmbh
https://twitter.com/giz_gmbh

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Abbreviations

BMZ	German Federal Ministry for Economic Cooperation and Development
CSPS	Civil society and private sector
DAC	Development Assistance Committee
EMRO	Eastern Mediterranean Region
EU	European Union
FC	Financial cooperation
FGD	Focus group discussion
FP(s)	Focal person(s)
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
HeRAMS	Health Resources and Services Availability Monitoring System
ICO	International cooperation office
IDP	Internally displaced people
IDSR	Integrated disease surveillance and response
IMC	International Medical Corps
IOM	International Organization for Migration
KAP	Knowledge, attitude and practice
KfW	Kreditanstalt für Wiederaufbau (German Development Bank)
LNOB	Leave No One Behind
MEAL	Monitoring, evaluation and learning
mhGAP	Mental health gap action programme
MHPSS	Mental health and psychosocial support
MoH	Ministry of Health
MSNA	Multisector needs assessments
NCD(C)	Non-communicable disease (control)
OECD	Organisation for Economic Co-operation and Development
PCI	Primary Care International
PFA	Psychosocial first aid
PHC	Primary health care
PHCC	Primary health care centre
PHCI	Primary Health Care Institute
RBM	Results-based monitoring
SARA	Service Availability and Readiness Assessment
SDG	Sustainable Development Goal
TC	Technical cooperation

UHC	Universal health coverage
UNICEF	United Nations Children’s Fund
WHO	World Health Organization



The project at a glance

Libya: Improving Primary Health Care (PHC) provision

Project number	2018.1827.7
Creditor reporting system code(s)	16050 – Multisector aid for basic social services (100%)
Project objective	The PHC provision in Libya is improved with regard to service quality, accessibility, and orientation towards social cohesion
Project term	September 2018 – March 2025
Project value	EUR 17,798,000
Commissioning party/co-financier	German Federal Ministry for Economic Cooperation and Development (BMZ)
Lead executing agency	Ministry of Health (MoH)
Implementing partner organisations (in the partner country)	Primary Health Care Institute (PHCI) National Centre for Disease Control (NCDC) Municipal Councils District Health Management Teams Ministry of Local Government (MoLG) International Medical Corps (IMC) Primary Care International (PCI)
Target group(s)	Managerial and medical staff of Primary Health Care Centres, the district health management teams, municipalities and selected representatives of the population including vulnerable groups. Population in the selected municipalities (approximately 700,000), namely population groups affected by poverty and disadvantaged groups: women and girls, older people, people in need of psychosocial support, people living with disabilities, survivors of violence, internally displaced people (IDP) and migrants
Development cooperation (DC) programme	Not applicable
Implementing organisations of the DC programme	Not applicable
Organisation responsible for implementing and coordinating the DC programme	Not applicable
Reporting year of CPE	2023
Sample year of CPE	2019

1 Evaluation objectives and questions

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

1.1 Evaluation objectives

Central project evaluations of projects commissioned by the German Federal Ministry for Economic Cooperation and Development (BMZ) fulfil three basic functions: they support evidence-based decisions, promote transparency and accountability, and foster organisational learning within the scope of contributing to effective knowledge management. Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH structures the planning, implementation and use of evaluations so that the contribution the evaluation process and the evaluation findings make to these basic functions is optimised (GIZ, 2018a). This is an interim evaluation. The project has been selected as part of the Evaluation Unit's random sample. Due to travel restrictions for the international evaluator, a semi-remote evaluation with a local evaluator was conducted inside Libya while the international evaluator worked remotely.

1.2 Evaluation questions

The project is assessed on the basis of standardised evaluation criteria and questions to ensure comparability by GIZ. This is based on the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) evaluation criteria (updated 2020) for international cooperation and the evaluation criteria for German bilateral cooperation (BMZ, 2021): **relevance, coherence, efficiency**, **effectiveness**, **impact** and **sustainability**. Specific assessment dimensions and analytical questions have been derived from this framework. These form the basis for all central project evaluations in GIZ and can be found in the **evaluation matrix** (Annex). In addition, contributions to the Agenda 2030 for Sustainable Development and its principles are considered, as well as cross-cutting issues such as gender, the environment, conflict sensitivity and human rights. Also, aspects regarding the quality of implementation are included in all OECD DAC criteria. Knowledge interests of stakeholders beyond the standard evaluation questions have been included in the relevant sections of this report as shown in Table 1.

Table 1: Knowledge interests beyond standard evaluation questions by main evaluation stakeholder groups

Evaluation stakeholder groups	Knowledge interests in evaluation/ additional evaluation questions	Relevant section in this report
BMZ and GIZ	Effectiveness of implementing social cohesion measures in a health project?	Included in **effectiveness** and **impact** criteria
GIZ	How and to which degree does the project apply feminist development policies?[1]	Included in the **relevance** and **impact** criteria

[1] Ten recommendations for Germany's Feminist Development Policy (Friesen I and Wisskirchen A, 2022).

2 Object of the evaluation

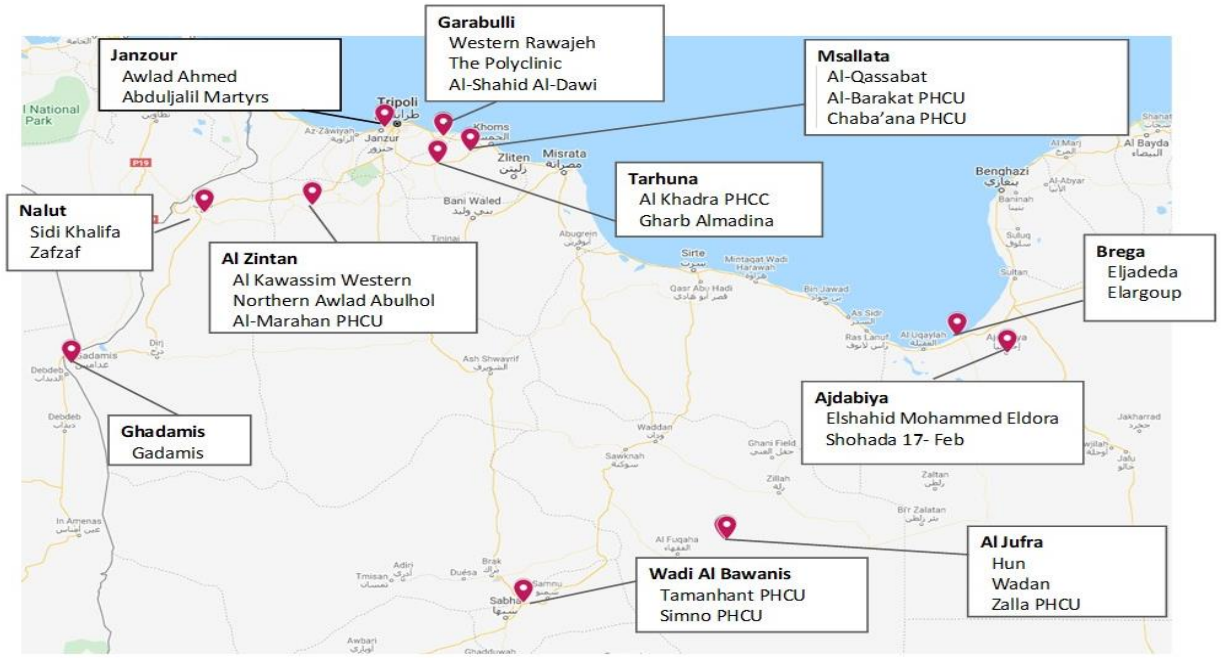
This chapter aims to define the evaluation object, including the theory of change, and results hypotheses.

2.1 Definition of the evaluation object

The object of evaluation is the Improving Primary Health Care Provision project, identified by project number 2018.1827.7. The assessment and grading according to the OECD DAC criteria only refer to this project. The project duration is from 1 September 2018 to 31 March 2025 and its total value is EUR 17,798,000 provided exclusively by the BMZ without any co-financing. The monetary value of partner contributions is estimated at EUR 218,647. The possible replenishment in 2023 may increase the project value and duration; this will be considered in the conclusions from the evaluation but not in answering the evaluation questions.

The project is steered remotely from Tunis by international staff and coordinated in Libya by a local team. Interventions are implemented in 12 municipalities in a total of 25 primary health care centres (PHCCs). The project also works with the Ministry of Health (MoH) and some of its agencies, especially the Primary Health Care Institute (PHCI) and the National Centre for Disease Control (NCDC). The number of municipalities and PHCCs increased over time. Implementation in Jakharra was only agreed in the last modification proposal and activities will start within 2023. Figure 1 shows the geographical distribution of the supported PHCCs.

Figure 1: Map of PHCCs supported by the project (as of January 2023)



Source: Adapted from a map provided by the project

Initially, the project was designed to improve the functionality of seven selected PHCCs (thematic area 1) and to enhance the competencies of primary health care (PHC) staff (thematic area 2). By the time of the evaluation, the original proposal has been modified four times due to conceptual changes and increased funding. The project value now is threefold higher than at the beginning. The thematic changes reflect:

- The response to COVID-19.
- Two new thematic areas, namely strengthening epidemic preparedness in municipalities (3) and enhancing access to community-based psychosocial-support services (4).

- A deeper and broader conceptual approach in thematic area 1 from the more humanitarian approach to increase the functionality of seven selected PHCCs towards a stronger focus on management capacity across all facilities and all municipalities benefiting from the project.
- A change in strategy for thematic area 2 shifting from singular more ad hoc trainings to a more systematic and systemic PHC training approach.

The project is funded under BMZ's Strategy on Transitional Development Assistance (BMZ, 2020). BMZ aims to 'support affected people and local structures in overcoming crises and strengthening their resilience' (ibid., p.2). The project was designed in a fragile context following the toppling of Qaddafi in 2011. The UN-supported Action Plan for Libya failed when the Eastern-based Libyan National Army tried to seize Tripoli in April 2019. The Government of National Unity was established in Tripoli but failed to hold nationwide elections which were originally scheduled for 24 December 2021. In the east, the House of Representatives set up the Government of National Stability in March 2022 (German Embassy, 2023). Currently, competing actors and institutions make it difficult to advance reforms (ibid.). Libya's trade balance has gone from a deficit to a surplus of 21% in the first half of 2022. However, the majority of the population benefits to a limited extent and suffers from high inflation: in 2022 the price of the minimum expenditure basket has increased by 37% (ibid.). 'The human rights situation has not improved in 2022 and remains consistently poor' (ibid., p.2). Libya is a destination and transit country for irregular migration (ibid.). The provision of health services, schooling, water, and energy supply remains poor due to a lack of skilled personnel, poor management, and insufficient funding. Some infrastructure damages from the civil war have not yet been repaired (ibid.). The highly centralised health sector is disrupted. The conflict has deepened problems that existed prior to 2011 including poor primary health care, an overreliance on hospitals and limited services in remote areas (Irhiam, 2023). The Libyan authorities define the top challenges as follows: fragmentation of health sector institutions, weak governance, lack of accountability, extreme shortages of medical supplies and health staff; a badly disrupted PHC network, and severe funding shortages (OCHA, 2022 p.1). COVID-19 was an additional shock to the health system. The MoH issued a decree giving municipalities sole responsibility for COVID-19 preparedness and response through the creation of municipal emergency coordination committees. However, the municipalities were not sufficiently equipped to take primary responsibility for COVID-19 control (GIZ, 2021a).

2.2 Results model including hypotheses

The project's objective is to improve PHC in selected communities in Libya. The political partner of the project is the MoH. In the project context, it is mainly represented by the International Cooperation Office (ICO) and two agencies under the MoH, the PHCI and the NCDC. Other implementing partners are the municipalities under the Ministry of Local Governance, the district health management and the PHCCs. During the COVID-19 pandemic, selected hospitals were also implementation partners. The International Medical Corps (IMC) provided tailor-made support at the health facility (micro)-level until 2022 and Primary Care International (PCI) currently prepares a PHC training package. Direct target groups are the managerial and medical staff involved with PHC and selected representatives of the population including vulnerable groups. During COVID-19, selected hospital staff also benefited from capacity development. Indirect target groups/final beneficiaries are the population in 12 municipalities. The project aims to reach vulnerable groups, namely women, girls, older people, people in need of psychosocial support, people living with disabilities, survivors of violence, and IDP migrants who may be disadvantaged in terms of access to PHC.

The project has a theory of change (ToC) which describes how the different activities will lead to changes at the level of the direct target groups (**outputs**), how these will lead to the project objective (**outcome**) and how this outcome will contribute to higher-level development goals (**impact**). At GIZ, the ToC is visualised in a results model. The current results model (see Figure 2) was updated during the inception period and reflects the current ToC including the adaptations of the project strategy since 2018/19. The corresponding results hypotheses are explained narratively as follows (the letters and numbers refer to Figure 2):

Output level

The project encompasses four **outputs**, namely:

Output A: Improved PHC provision at municipal level. The **key activity until end 2022** was tailored support to seven PHCCs by IMC also including patient treatment when required (**A1**). **Key activities now** are management workshops and follow-up across all 12 municipalities (**A2**). The activities A1 (**H1**) aimed at improving functionality of seven PHCCs (**R1**). A2 instead (**H2**) aim at developing the management capacity within the municipality based on the Family Practice Approach (**R2**).[2] Health managers are expected to adopt new management routines (**R3**) and establish inclusive municipal health working groups for participatory planning and steering (**R4)** to improve PHC provision (**OP A**). The **key underlying assumptions** are that PHCI would provide sufficient support and that enough health workers would be at their workstation. In view of management, the **assumption** is that partner staff and communities engage in the process. **Risks** for achieving R1 were the limited availability of (motivated) staff, challenges with procurement and distribution of material (including essential medicines and supplies) and security issues preventing IMC staff and health care providers to come to work. The main **risks** related to R2–R4 are political and administrative. **Additional risks** include a lack of interest to adopt new managerial practises as well as socio-cultural barriers, including stigma, fear, and travel barriers for women.

Output B: Improved competencies of the PHCC staff. The initial key activity was training of individuals (**A3**). Key activities now include (**A4)** developing a competence-based in-service training framework, PHC training modules and the training of trainers. It is expected that PHCI and its partners will use the inputs to provide standardised in-service training for PHC (**R5**). One of the new management routines (**R3**) expected to result from output A is the strategic selection of trainees (**R6**). The approach (**H3**) should improve the competencies of PHC staff (**OP B**) who would thereby provide a broader range of standardised services (**R7**) and refer patients correctly (**R8**). The **key underlying assumptions** are that the MoH will endorse the training, and that trained staff will have adequate equipment, supplies and medicines to apply what they will have learnt. The main **risk** is that funds and management capacities will not suffice to ensure the provision of infrastructure, consumables and medicines to apply what was learnt. Another **risk** is that human resource management will fail to ensure that trained staff will stay in charge for the services they have been trained for.

Output C: Strengthened epidemic preparedness was introduced in response to COVID-19. The **key activity** was a rapid needs assessment in the 16 municipalities supported by the GIZ Libya cluster. (**A5**). Relevant information (**R9**) would allow partners, the BMZ and the cluster to mount their COVID-19 response (**H4**). The project provided training on essential PHC services, testing and treatment of COVID-19, and asset management. Together with IMC, it supported patient management and provided protective equipment. An additional five PHCCs in the west received training and goods to maintain essential services. The project also procured equipment for five hospitals and three mobile laboratories. Medical and nursing staff and laboratory technicians received training and supervision (**A6**). It was expected (**H4**) that thereby municipalities would maintain PHC provision and establish COVID-19 testing and treatment (**R10**). Now, it is expected that the mobile labs will continue to work as reference laboratories for surveillance (**R11)**. From 2023, the project will support piloting and expanding event-based surveillance of communicable diseases at the community level as part of an Integrated Disease Surveillance and Response System (IDSR, **A7**). This **(H5)** should enable municipalities to alert local NCDC branches of potential outbreaks in their communities and to effectively mobilise their communities in response to disease outbreaks **(R12)** thus strengthening epidemic preparedness in selected municipalities **(OPC).** The **key assumption** for results **R9–R10** is the willingness of all actors to engage in the COVID-19 response. The main **risks** were false information, reduced availability of health staff due to COVID-19 and delays in the arrival and distribution of the procured equipment. The **key assumption** concerning **R11** is that all three laboratories will be accredited. The **key risk** is that the laboratories will not

[2] The Family Practice Approach [7.3.2023] is a service delivery approach promoted by the World Health Organization's Regional Office and informally endorsed by Libya's MoH.

receive continuous supplies. For **R12**, the **key assumption** is that NCDC will make rapid progress in developing the IDSR. The main **risk** is that means and structures for event-based surveillance are not agreed upon quickly enough and project activities would be delayed.

Output D: Improved access to community-based psychosocial-support services. Key activities consist of training PHC staff (**A8**) to provide basic mental services as well as non-medical focal persons (FPs) on mental health and psychosocial support (MHPSS) at the community level. The project supports the mapping of MHPSS services (**A9**) and networking between the trained providers and FPs (**A9**). The FPs are expected to improve knowledge and skills regarding MHPSS within the community (**R13**) and to pass on their knowledge and skills (**R14**). These changes (**H6**) aim at a functioning network engaging MHPSS multipliers at the community level to promote psychosocial awareness and activities in the communities and effectively link the communities to the PHCCs for basic mental health care (**R15**). This is expected to improve access to community-based psychosocial-support services (**OP D**). The **key assumptions** are that MoH endorses the concept of MHPSS FPs, that enough volunteers can be mobilised as FPs and that MoH allows trained doctors to provide mental health services at the PHCCs. One **risk** is the lack of higher-level services to which patients can be referred for specialised MHPSS. Another **risk** is stigmatisation of persons with mental health issues.

Outcome and impact level

Outcome level: All above-mentioned outputs should contribute to improved PHC provision in Libya in selected communities in terms of quality, access and the orientation towards social cohesion (**project objective**). Other expected results are the use of experience from the project for a national PHC strategy and other strategies (**R16**) and the use of the community-based surveillance pilots for the consolidation of a national IDSR (**R17**). It is also envisaged that the project results will jointly increase contact and communication across all actors – community level, PHC providers, municipality/district, central level and between the east, west and south – and thereby reduce the existing disconnect between administrative levels (**R18**).

Impact level: By achieving its objective, the project would contribute to equity, efficiency and quality of health care in Libya (**I1**) even beyond the intervention sites if the approaches are endorsed, sustained and scaled up by MoH. This could eventually lead to Universal Health Coverage (UHC) (**I2**) as the centrepiece of the sustainable development goal (SDG) 3: health. SDG 3 contributes to the key promise of the Sustainable Development Agenda 2030, Leave No One Behind (LNOB) and is interwoven with the following SDGs: End poverty (1); Quality education and lifelong learning (4); Gender equity (5 and DAC cross-sectoral policy **GG**); and reduced inequalities (10). **I3** contributes to SDG 16 (peace, stability and strong institutions) and corresponds to the supra-sectoral policy marker peace and security (FS), the aim of transitional development assistance[3] and nexus and peace partnerships.[4] By improving communication (**R18**), the project aims to contribute to trust and accountability in the health system (**R19**) as a contribution towards peace.[5] The **key underlying assumptions** are that political processes will evolve towards stabilisation, that reconstructing the disrupted health sector remains a priority of the government and international partners, and that adequate health financing mechanisms will be installed. The **main risk** for achieving the **project objective** are delays due to administrative, political and security issues. Although the Ministry of Foreign Affairs officially allowed GIZ to continue their projects during their accreditation phase, the ICO of the MoH suspended the project's activities between February and September 2022. The main **risks** at the **impact level** are that the necessary

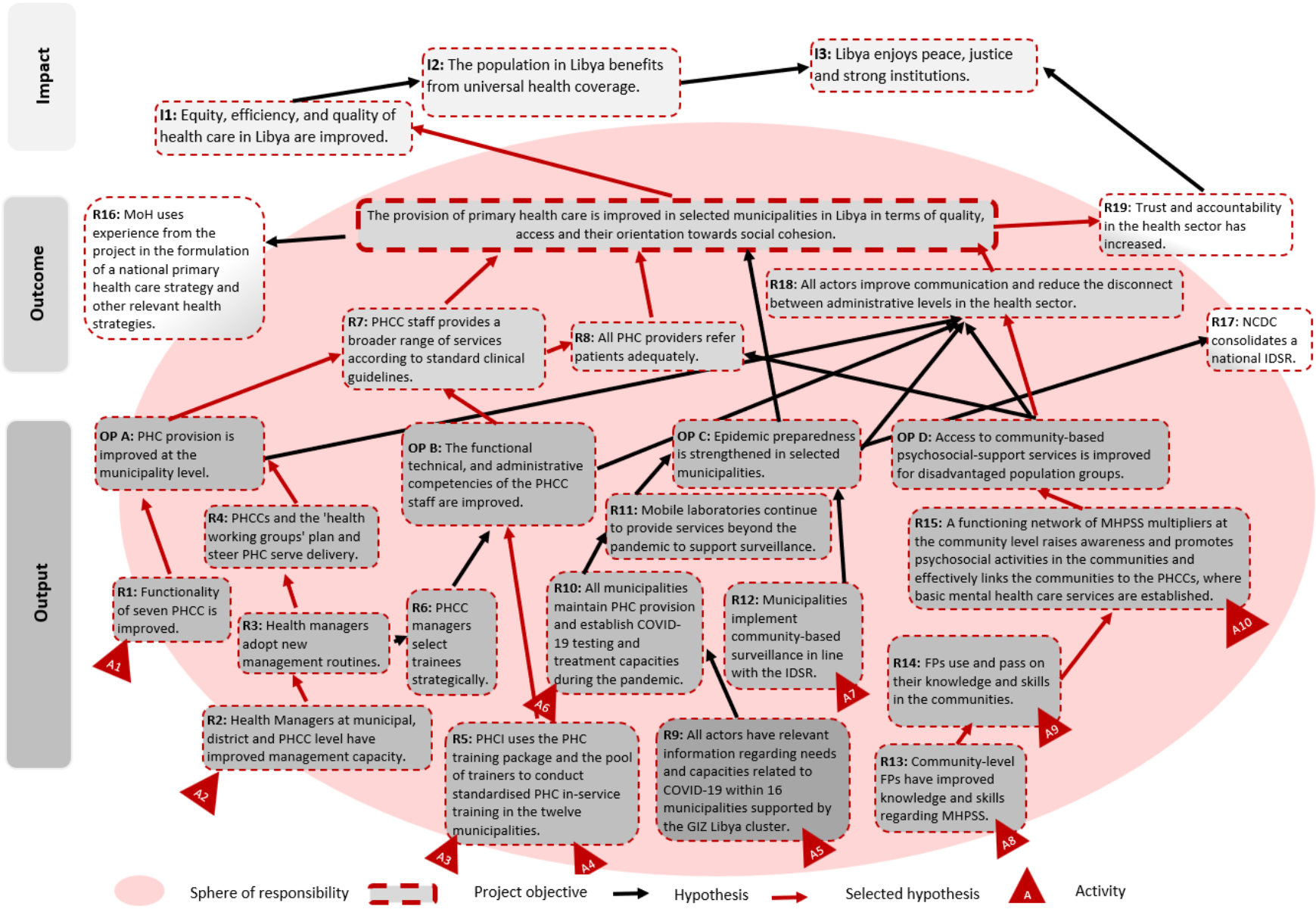
[3] Transitional development assistance aims at supporting affected people and local structures in overcoming crises and strengthening their resilience (BMZ, 2020).
[4] Nexus and peace partners are a category of BMZ's partner countries. Libya is one partner in this category. In these countries, cooperation aims at tackling the structural causes of conflict, displacement and violence and provide support in peacebuilding [10.3.2023].
[5] UNDP underlines that 'Strengthening mutual trust between the state and the citizenry and among communities is considered essential to build resilience and achieve durable peace and stability, especially in conflict-affected regions and countries and/or fragile, violence-affected settings' [10.3.2023].

policies and strategies towards UHC will not be developed and endorsed at national level and that funding and implementation of the policies and strategies remain inadequate.

System boundary

The sphere of responsibility clearly ends with improved PHC service delivery within the 12 supported municipalities. It is important that the project is responsible for gradual improvements (project objective) but cannot ensure efficient and effective service delivery (impact) without the contribution of various government institutions. At the system boundary, the project aims to contribute to three results, namely improved policies, and strategies (**R17**), the new IDSR (**R18**), and improved trust and accountability in the health sector (**R19**). These results are largely beyond its sphere of influence but could be achieved by building on the project's results.

Figure 2: Current results model (March 2023), adapted during the inception period



3 Evaluability and evaluation process

This chapter aims to clarify the availability and quality of data and the process of the evaluation.

3.1 Evaluability: data availability and quality

This section covers the following aspects:

- availability of essential documents,
- monitoring and baseline data including partner data, and
- secondary data.

Availability of essential documents

Most essential documents were available in time except for an up-to-date results matrix. The inception report was used to agree on specifications of the indicators for the purpose of the evaluation and suitable sources. The narrative part of the essential documents was adequate, but data was limited to track progress towards the indicators. There is no country strategy for German or European cooperation. Libya has no written health strategy. An overarching reference framework to assess the criterion relevance was constructed through the SDGs, a detailed and very clear report from the German Embassy and BMZ's Transitional Development Assistance Strategy. The limited availability of documents was also partly compensated through verbal communications of key informants, from BMZ, the Embassy, GIZ headquarters and the Libya cluster.

Monitoring and baseline data including partner data

The project's result-based monitoring (RBM) contributed only limited data to the evaluation. Relevant data for several indicators has not yet been collected. The project has conducted qualitative interviews (KOMPASS) to assess the impact of interventions at the PHCCs and in the context of COVID-19. The evaluators received an EXCEL spreadsheet with categorised quotes for the PHCC impact and the transcripts of interviews for COVID-19. Through surveys, the project collected baseline data of sufficient quality for the outcome indicator 'patient satisfaction' and two output indicators (functionality and range of services. However, satisfaction was only assessed by rating during exit interviews, and the rationale for the rates was not systematically assessed. The data was made available. All other indicators have 0 baselines because they measure improvements following project interventions (GIZ, 2023a) The baseline status was partly based on the World Health Organization's (WHO) Service Availability and Readiness Assessment (SARA) of the public health facilities in Libya (ter Veen, 2017) and needs assessments by the project (Proximity International/IMC/GIZ, 2020; IMC 2020a; 2021a). These surveys followed precise approaches and are of good quality. The project presented some data to track progress towards output indicators which was patchy and had to be verified through repeated email exchange. In the past, national partners have not collected data which could be used to monitor the project indicators. The project is introducing a routine qualitative and quantitative patient satisfaction tool for PHCCs, and it has supported the roll-out of a national health information system based on DHIS2.[6] MoH didn't give the evaluators access to the DHIS2 data. Overall the monitoring data was incomplete, and of limited quality.

[6] DHIS2 is an open-source software that is a generic tool allowing the user to design the contents of a specific information system without the need for programming. Libya has started to build its health information system using this tool and the project supported the roll-out through training courses.

Secondary data

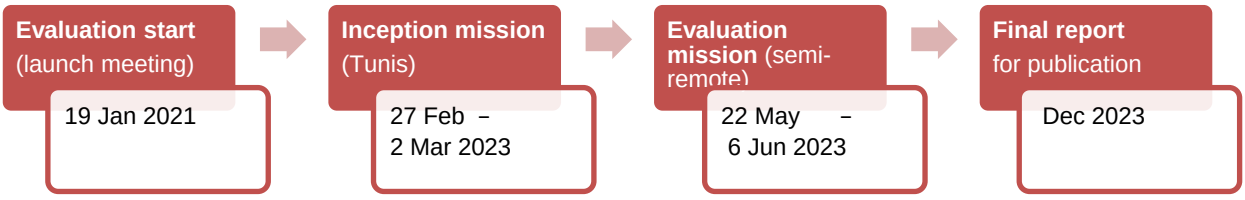
Secondary data was scarce and outdated. This problem was also faced by other agencies and the MoH (Inception workshop, Int_2,5 donor; AESEA Consortium, 2022). World Bank is currently implementing a Health Service Delivery Indicators Survey, but no data is yet available. The SARA 2017 (ter Veen, 2017) was not repeated. The last available data from the Health Resources and Services Availability Monitoring System (HeRAMS) is from 2021 and included only 29 health facilities. SARA and HeRAMS use different scoring systems to measure functionality of health services; data cannot be directly compared but it can be triangulated to understand broader trends. According to SARA the general readiness score was 45% for PHC facilities; according to HeRAMS 66% of the visited PHCCs were fully functioning. This may indicate a positive trend regarding the functionality of PHCCs between 2017 and 2021. WHO data from monitoring health and health system performance in the Eastern Mediterranean Region (EMRO) in 2021 is aggregated at national level but it's partly old, so can't be used to measure project progress. Secondary data from the multisector needs assessments (MSNA) can be accessed from the Resource Center. MSNAs provide data on health access barriers on an annual basis. Unfortunately, from the project intervention municipalities, only Al Jufra is part of the sample. Data on migrants' health needs on a national level of aggregation was found in the migrant report 2021 from the International Organization for Migration (IOM). Secondary data to assess the criterion Relevance was taken from the executive summaries of local development plans which were provided by the Promoting Decentralisation to Contribute to Stability in Libya project (PN 2018.2181.8). Overall, the quality of secondary data was good but the available secondary sources were only partly relevant to assess the project.

3.2 Evaluation process

This section covers the following aspects:

- milestones of the evaluation process,
- involvement of stakeholders,
- selection of interviewees,
- data analysis process,
- roles of international and local evaluators,
- (semi-)remote evaluation (if applicable), and
- context and conflict sensitivity within the evaluation process (if applicable).

Figure 3: Milestones of the evaluation process



Involvement of stakeholders

The evaluators aimed at a participatory process. Stakeholders were involved in the design of the evaluation in the inception period through interviews and an inception workshop in Tunis. Face-to-face interaction was only possible in Tunis and during field visits in Al Jufra, Janzour and Wadi al Bawanis municipalities. A female interviewer was recruited to include the voice of female beneficiaries. Online and phone interviews, online focus group discussions (FGD), WhatsApp group chats and two small online surveys were conducted to engage with stakeholders from municipalities, national partners, international organisations, donors, GIZ headquarters, all project staff members and other key informants, who could not be visited. Over 160 stakeholders helped to build the database for this evaluation with their views and experiences. They were informed that the report will be available on the GIZ website. A sub-set of stakeholders also participated in an

online kick-off meeting with a presentation and discussion of preliminary results on 8 June 2023. Upon request, discussion sessions with specific stakeholders can be agreed after the end of the evaluation.

Selection of interviewees

Table 2 summarises evaluation stakeholders and the formats of engagement. They were selected in view of knowledge about the project and/or knowledge about institutional capacities and context and/or knowledge about direct and indirect target group's needs and perceptions. The selection was based on recommendations from the project and the participants of the inception meeting. Additional interviewees were proposed throughout the evaluation interviews. The evaluators decided by themselves who to contact aiming to reach the broadest spectrum of views within the available resource framework (time, cost). Ultimately, participants self-selected by responding to the interview requests and/or participating in surveys and group chats.

Table 2: List of evaluation stakeholders and selected participants

Organisation/company/ target group	Overall number of persons involved in evaluation	No. of interview participants	No. of FGD & Chat participants	No. of workshop participants	No. of survey participants
Donors	4f/2m	6			
BMZ, Embassy, European Union (EU), WHO, UNICEF, KfW					
GIZ	14f/10m	23	9[7]	5	0
GIZ project team, GIZ headquarters Germany, GIZ Libya cluster,					
Partner organisations (direct target group)	15f/44m	31	0	4[8]	35 invited[9] 27 responded
District Managers, PHCCs, MoH					
Civil society and private sector actors (CSPS)	19f/21m	24		2	0
IMC, PCI, Consultants, MHPSS FPs, Key informants on vulnerable groups, Health Representatives, Mayor					
Final beneficiaries/ indirect target groups (sum)	16f/17m	18	0	0	0
Clients of PHCCs					
Note: f = female; m = male					

Data analysis process

All interviews, FGDs and chats were conducted using semi-standardised guides based on a generic interview guide. The questions were individualised for each interviewee and adapted throughout to triangulate information from earlier interviews. Most interviews were recorded and transcribed; if this was not possible, notes were taken. Interviews in Arabic and German were translated into English. Data was also taken from documents (see References). Documents and interview transcripts were qualitatively analysed using the evaluation questions from the evaluation matrix (Annex) as categories. The data was then summarised and

[7] FG participants also had individual interviews.
[8] One Inception workshop participant was also interviewed.
[9] Ten survey participants were also interviewed

organised in an EXCEL spreadsheet following the six evaluation criteria. For the two surveys, 35 participants have been invited (Survey I:11; Survey II: 24). The overall response rate was 27 out of 35 (77%) with 100% response for Survey I and 67% for Survey II. Univariate analysis was used to summarise the anonymised perceptions regarding selected evaluation questions quantitatively, the quantitative results were used to triangulate the qualitative findings. Financial data was analysed using GIZ's efficiency tool which helped to attribute costs to outputs and outcomes and thereby served as a basis to formulate the interview questions for the criterion Efficiency.

Roles within the evaluation team

The evaluation team includes two persons, an international and a national evaluator. The international evaluator coordinated the overall process, conducted remote interviews and FGDs in English and German, led the analytical process, and wrote the report. The national evaluator communicated with the ICO at the MoH in close coordination with the project, conducted the field visits and all interviews and chats in Arabic. A female interviewer was recruited to increase acceptability of an interviewer by women. She interviewed patients/clients of the health facility and staff. The national evaluator oversaw her work and ensured the translation of all data collected in Arabic into English. Throughout the evaluation process, both evaluators supported each other in exchanging interview transcripts and providing feedback to each other and to prepare the presentation of preliminary findings at the end of the evaluation mission.

(Semi-)remote evaluation

Due to security and cost considerations, the evaluation was **semi-remote.** Only the local evaluator was inside Libya. Remote interviews started prior to the official kick-off to allow for more flexibility for appointments and time for transcripts and translation. Despite these precautions, the time frame was very tight: The need for translation and the limited time to do this during the field visits partly delayed the exchange on the results of the interviews, FGDs and chats between the evaluators. Therefore triangulation of information during the period of data collection was limited. This restricted the evaluators' ability to adjust the evaluation questions flexibly to the incoming information and may have had an effect on the depth of the assessment. This was partly mitigated through joint review and interpretation of findings after the end of data collection.

Context and conflict sensitivity within the evaluation process

The evaluation was an intervention in the project context and its fragile environment. The evaluators anticipated specific risks and took precautions. There were no critical issues or conflicts during the evaluation. To avoid that the evaluation would be perceived as a form of control, each participant of the evaluation was informed about the purpose of data collection and was assured that data will be kept confidential. Every participant was also asked if they had any requests for the evaluators and the evaluators complied with the request. For example, some participants wished to receive the protocol of the interview and the evaluators complied. Furthermore, to ensure adequate legitimation and access to PHCCs, the evaluators had obtained a letter from ICO. To avoid any repression, stigmatisation or discomfort, data from key informants for vulnerable groups was collected online. Female clients and some female partners were interviewed by a female interviewer. The evaluators had a briefing with GIZ's risk management office. Security clearance was obtained prior to travel and all security advises including travel in a car with a driver were respected.

4 Assessment according to OECD DAC criteria

4.1 Impact and sustainability of predecessor projects

Because the project was a new transitional development assistance measure when it started in 2018, there was no predecessor project, therefore none to evaluate.

4.2 Relevance

This section analyses and assesses the relevance of the Improving Primary Health Care Provision project.

Summarising assessment and rating of relevance

Table 3: Rating of OECD DAC criterion: relevance

Criterion	Assessment dimension	Score and rating
Relevance	Alignment with policies and priorities	28 out of 30 points
	Alignment with the needs and capacities of the beneficiaries and stakeholders	27 out of 30 points
	Appropriateness of the design*	18 out of 20 points
	Adaptability – response to change	20 out of 20 points
Relevance total score and rating		Score: **93 out of 100 points** Rating: Level 1: highly successful

The project design was aligned with the objective of BMZ's Transitional Development Assistance Strategy to 'support affected people and local structures in overcoming crises and strengthening their resilience'. By deploying the activities close to the target groups at the municipal level it was geared to operationalise the nexus and peace partnership between Germany and Libya. The project aligned with national priorities: it supported the Family Practice Approach and the implementation of the national COVID-19 response plan. It was aligned with the needs and capacities of the PHC providers and managers and reflected the need of the population for accessible primary care. The evaluators saw limited scope for identifying and meeting specific needs of disadvantaged population groups including migrants. The project pursued a do-no-harm approach, for example through a participatory data-driven process to select its intervention sites. With increased funding and extended duration, the project concept evolved from a limited focus on service delivery to a broader social cohesion and health system-oriented intervention. This was based on scalable and internationally recognised approaches and a plausible and verifiable ToC. The project was fast, focused, and effective in responding to changes in the environment including the COVID-19 pandemic by making consistent use of good partner relations and networks. The project would have achieved full points if aligned more with BMZ's strategic emphasis on stronger integration of impact and evaluation approaches.

In total, the relevance of the project is rated as Level 1: highly successful, with 93 out of 100 points.

Analysis and assessment of relevance

Relevance dimension 1: Alignment with policies and priorities

The assessment considers the alignment of the project objectives with the BMZ Strategy on Transitional Development Assistance and the European Council Conclusions on operationalising the humanitarian-development nexus. With regard to the fragile context, the reflection of the integrated peace and conflict assessment (iPCA) in the project design is also assessed.

The project objective to improve PHC provision with regard to service quality, accessibility and orientation towards social cohesion (GIZ, 2021a) is in line with the BMZ strategy's objective to 'support affected people and local structures in overcoming crises and strengthening their resilience' (BMZ, 2020b, p.1). The emphasis on building structures for resilience evolved with the modification proposals focusing on different levels of capacity which reflect the European Council Conclusions on the humanitarian-development nexus: stabilisation (re-establishing functionality of the PHCCs), adaptation (knowledge and competences of health care providers and health managers), and transformation (contributing to the establishment of a primary care-oriented health system). By deploying activities locally and close to the target groups, the project was geared to operationalise the nexus and peace partnership between Germany and Libya. It was set to rebuild the basic infrastructure of selected PHCCs and to promote social cohesion, e.g. by fostering exchange between health workers from west and east, by addressing the disconnect between the hierarchical levels and by promoting equal and gender-sensitive access to PHC services. The project tied in with humanitarian aid by participating in the UN-led health cluster coordination structures and was integrated with the GIZ Libya cluster, which combines various projects all aiming to strengthen municipal structures (see the criterion Coherence below). While responding to the fragile context due to the conflict, the project also responded to the COVID-19 pandemic. It aligned with national strategies and priorities wherever they existed in the disrupted health system (see dimension 3). BMZ emphasises the stronger integration of impact and evaluation approaches (2020b). While the project design was strong on evidence for the selection of municipalities, the focus on evidence was less prominent once implementation started (Int 13,15,18 GIZ, FGD III and conclusion of the evaluators). The project concept adequately reflected the Peace and Conflict Analysis for Libya (Wood, 2018) and the updated iPCA (GIZ, 2021b) aimed at sustainable impact within the fragile context in line with its peace and security marker FS1.

In summary, the project was aligned with policies and priorities except in view of an orientation on compiling evidence as postulated by BMZ's Strategy on Transitional Development Assistance. Therefore, 2 points were deducted.

Relevance dimension 1: Alignment with policies and priorities – scores **28 out of 30 points.**

Relevance dimension 2: Alignment with the needs and capacities of the beneficiaries and stakeholders

The assessment looks at how the project design aligns with the needs and capacities of the direct and indirect target groups including potentially disadvantaged and vulnerable beneficiaries (see Box below). Because of the fragile context, the assessment also looks at the identification of causes for tension (dividers[10]) and approaches to reduce tensions (connectors[11]) and security risks.

The project aimed at improved access. It assumed that people would have better access to primary care if the PHCCs were better managed, staffed, equipped and supplied with medicines, if staff had improved competences and if access barriers were removed. Financial access was not addressed by the project. Initially, the project objective read 'PHC has improved in terms of quality and access for vulnerable groups in selected communities in Libya' (GIZ, 2018). However, specific interventions for particular groups were not defined. The

[10] Dividers and escalating factors can be seen as sources of tension, for example destructive institutions, structures, norms and behaviour. For more details, see: GIZ, 2007.
[11] Connectors and deescalating factors are the opposite, instead taking the form of peace-promoting actors and institutions, structural changes, and peace-promoting norms and behaviour. For more details, see: GIZ, 2007.

term vulnerable groups disappeared from the objective with the modification offer and the focus shifted its orientation towards social inclusion (GIZ, 2021a, c). Some health care workers, managers and clients hold the opinion that all Libyans have full access to PHCCs and therefore there would be no need for specific interventions or disaggregated monitoring (Int 1, 5–8, 15–17, 20–25 partner, Int 22, 31–32 client). Other interviewees identified the vulnerable groups as the elderly, people with disability, women without car, women in the last month of pregnancy, widows, immigrants, migrants without ID, poor people, and people who live in remote areas (Int 10, 23 partner; Int 5 CSPS; Int 3, 19, 24, 28–30 client; Int_8 GIZ, Chat I, II). Many interviewees state that medicines, lab-tests or services must be purchased from the private sector if the PHCCs cannot provide them (Int 1, 5, 8, 13, 19, 22, 23 partner, Int 2, 3, 7, 8, 11, 15, 19, 20, 31 client). Poorer people cannot afford this (Int 5, 8, 14, 23 partner). Also a lack of transport may prevent people who need care from coming to the PHCC (Chat II, Int 13 CSPS). In the beginning, the project provided direct support to few PHCCs: doctors, medicines and services were available. This was clearly addressing the concerns voiced by the interviewees and therefore in line with the needs of the target groups. However, it did not address the underlying issues at a health systems level (KOMPASS; Peters, 2022c). According to the modification offers, project progress reports, operational plans and interviews the project evolved towards a stronger focus on the needs for better management competences through a series of management workshops. The direct support to service provision was phased out. While multiple stakeholders and beneficiaries underline the relevance of the new focus, several informants state that PHCCS may not be ready to provide PHC service without a sustained support on-the-job, provision of medicines, equipment and doctors through non-governmental organisations. This will be further discussed under Sustainability.

Target group analysis (summary)

Direct target group: Technical and managerial staff of 25 PHCCs in 12 municipalities, district health managers, municipal health representatives, spokespersons of disadvantaged population groups, focal points for MHPSS, community multipliers and – during the COVID-19 pandemic – staff of selected hospitals (GIZ, 2022c, Inception Workshop). When the project started, the average functionality score of PHCCs was 30% in the west (Proximity International/IMC/GIZ, 2020) and 37% in the east (IMC, 2020a). Local health authorities lacked competencies and structures to effectively plan, steer and monitor PHC services. There was no effective communication between the PHCCs, local health authorities and the MoH (GIZ, 2022c).

The population living in the supported 12 municipalities amounts to 658,085 persons (calculated from data presented by the project in the inception workshop). 51% of them are male (World Bank, 2021). 610,128 migrants from over 44 nationalities were identified in the 100 Libyan municipalities during July to September 2021. Over three quarters (77%) of migrants reported a lack of access to basic healthcare (IOM, 2021). Currently, 33% households have severe (unmet) health needs (REACH, 2023). The gap is 7% higher for IDPs versus non-displaced persons.

The project was largely but not fully aligned with the needs of the direct target group, because civil society, PHCC staff and managers requested more direct support than the project provided (Surveys I & II; Int 1–25, 28, 30, 32 partner; Int CSPS; Int 8–9, 19, 21 GIZ, Chat I). No points were deducted because the evaluators agree with the view, that the existing gaps are a result of managerial and political issues which need to be solved as part of the humanitarian-development nexus (Int 26 partner, Int 1–2 donor, Int 4 CSPS, Int 8–9, 11, 15–17, 19, 21 GIZ, FGD I, II). The project was designed in line with the need of the population to access health care with better quality near to where they live. However, with the conceptual change, the project was no longer directly responding to these needs. The differentiation of special needs that may disadvantage individuals in view of accessing care still remains ‘work in progress’ after almost five years of project

implementation. Following a workshop with 'spokespersons' for 'vulnerable'[12] people which was conducted in parallel to the evaluation, it was felt that 'identifying the vulnerable groups from a Libyan perspective is the first step in determining which groups require support' (email communication with GIZ). The evaluators wish to underline this conceptual problem but acknowledge that direct interaction with the population in view of determining 'vulnerable' groups in a conflict-sensitive way is challenging in the given context (remote management, COVID-19 lock-down and interruption of project activities for seven months).

Connectors and dividers were identified in the iPCA and gender analysis (GIZ, 2021b. Schulz, 2021) and reflected in the project design throughout the modification proposals. The project supports the connectors, for example through the above-mentioned exchange between west and east during training in view of 'actively contributing to a unified response to challenges in the health care sector' (GIZ, 2021b, p.2) or the involvement of 'multiplicators at municipality level to foster participation' (ibid.). The best evidence for the project's active mitigation of potential risks and unintended negative effects in the shifting conflict dynamics was the very robust, transparent and participatory selection strategies for beneficiaries (Proximity International/IMC, 2020; IMC 2020a, 2021a, 2022a; Peters 2020a, 2022c). The importance of this strategy was also underlined in most of the interviews with GIZ, donors and other stakeholders. General security risks were specified in the project proposal(s) and the project was therefore designed with remote management. Security concerns have been considered when selecting the intervention sites. The project received daily confidential security reports from the GIZ Libya risk management office and finetunes operations as needed. In the years 2020–2021, the project also contributed to joint risk monitoring of the GIZ Libya cluster; however, the overarching cluster position has been vacant since then, and the monitoring at the cluster level has been discontinued (email communication). The evaluators did find indications of added value to the overarching risk monitoring from the past and did not see a negative impact for project implementation after the discontinuation. Therefore no points were deducted.

In summary, the project largely aligned to the needs and capacities of the beneficiaries and stakeholders. However, 3 points were deducted because of limited and late differentiation of project objectives and interventions for disadvantaged groups.

Relevance dimension 2: Alignment with the needs and capacities of the beneficiaries and stakeholders **–** scores **27 out of 30 points.**

Relevance dimension 3: Appropriateness of the design

The assessment focuses on the extent to which the methodological approach proposals are a realistic and plausible pathway towards reaching the intended results: the evaluators pay attention to the plausibility of the ToC, the consideration of partners at the border of the project's sphere of influence and the extent to which internal/external influences/risks have been factored into the design.

Upon request of the MoH, the intervention design relied on the Family Practice Approach developed by WHO EMRO [8.7.2023]. WHO affirms that this approach 'can increase household's access to a defined package of quality health services at an affordable cost' (2014, p.5). The gradual increase of supported PHCCs and municipalities as well as the addition of intervention areas reflected the increased financial volume of the project. The stepwise approach was realistic in view of the need to balance quick wins at selected PHCCs with competence development for management and structural changes for a longer-term impact. This was appropriate for a project in transitional development assistance (see dimension 1). However, the capacity of the disrupted Libyan health system was too weak to expect functioning PHC without major structural change and adequate funding (Int 7, 15, 20 partner). A partner stated that the analysis of the project was correct and helpful but that the project tried to address too many gaps at the same time. 'Maybe what was missed in the planning phase was to try to find the right sequence of priorities' (Int 26 partner). The evaluators think that the project

[12] The terms 'spokesperson', i.e. the criteria of who is entitled to speak on behalf of and the term 'vulnerable' are not clearly defined for the Libyan context. The evaluators therefore use the terms in single quotation marks.

might have been more realistically designed by focusing on a lesser number of succinct results, clearly defining milestones and risks, monitoring them meticulously, and steering the project towards the achievement of those succinct results before moving to the next set of milestones and results (see Effectiveness and Impact).

The ToC of the project (see Figure 2) changed over time. In the beginning the project focused on service delivery (GIZ, 2018) and evolved towards a more complex health systems-oriented and social cohesion-oriented approach (GIZ 2020a, b;2021a; 2022b). With the initial focus, the intervention design was very precise. It could have been criticised in terms of its plausibility because the claim/objective to focus on vulnerable groups assumed that PHC per se would benefit vulnerable groups. No points were deducted because at the time of starting the project, PHC services and the functionality of PHCCs were so poor (ter Veen, 2018) that from the evaluator's perspective a minimum level of functionality was a prerequisite for more specific approaches. Over time, the project maintained its focus on improving PHC provision. As depicted in Figure 2, the project outputs contribute directly to the project objective and partly reinforce each other, the underlying results hypotheses are plausible, and the evaluators were able to trace and verify these hypotheses and key assumptions in the evaluation (see Effectiveness and Impact). The selection of 'instruments'[13] (i.e. the grant agreement with a humanitarian service provider and the stepwise recruitment of national long-term advisors) was adequate to implement the interventions. The project's boundary partners (i.e. those partners who were close to but not within the project's sphere of influence) were the MoH, the GIZ Libya cluster projects and selected development partners, namely the UN agencies and the European Union. The project design reflected the use of scalable and shared approaches such as the Family Practice Approach and the active participation in coordination platforms. The main intended ripple effect was the federation of efforts towards strengthening PHC and increasing trust in and within the Libyan health system. Even though during COVID-19 the project has introduced certain activities at hospital level, the strong focus on PHCCs remained stable. The evaluators see the interventions at the hospital level as a contribution to the resilience of the health system and the population in the face of the pandemic, preventing the health system from collapsing. This was therefore a temporary priority within the overall design of the project. The project design included development opportunities for female health workers and need-based health care for women and girls. It took gender aspects into account when planning training events (see Effectiveness). Based on the assumption that the poor population are the main users of PHC, improving PHCCs contributed to the livelihood of the poor population: They could use scarce resources to meet other needs and did not have to spend money on health care. In addition, the project-initiated measures funded through the Study and Expert Fund to improve hospital waste management and thereby linked the interventions to the environmental dimension of sustainability.

In summary, the project design was largely appropriate, but 2 points were deducted because it might have been more realistic to focus on fewer succinct results.

Relevance dimension 3: Appropriateness of the design – scores **18 out of 20 points.**

Relevance dimension 4: Adaptability – response to change

The assessment looks at the extent to which the project identified significant changes in the context and how the project responded to these changes based on the four official change proposals.

Key potentials on the side of BMZ were repeatedly increased funding and the project extension (GIZ, 2020a, b; 2021a; 2022b). Key risks were COVID-19, the administrative challenges (namely the lack of registration of GIZ in Libya until September 2022) and the remote implementation. The project used additional funds to include more municipalities and to adjust the intervention strategy. Especially the risk of COVID-19 was thereby turned into an opportunity. The project proved to be fast, focused and effective in responding to changes (Int 2,10,11 GIZ, Int 1, 2, 3 donor); for example, by preparing a quick needs assessment at the beginning of COVID-19. The

[13] In German technical cooperation the term 'instruments' is used to describe the modes of delivery, e.g. financial contributions, materials, short and long-term advisors and development workers.

assessment was instrumental in adjusting the project interventions but also in federating the potential of the GIZ Libya cluster to contribute to the COVID-19 response (FGD III, Int 2, 11, 14, 20, GIZ). The project also seized the need for support in MHPSS expressed by the COVID-19 Emergency Committees as an opportunity and created a new intervention area (Int 11, 15, 16 GIZ). During the seven-months suspension (see section 2.2) the project was able to continue implementation on a reduced level though the implementation partners.

In summary, the project was very able to respond to risks and potentials by using its networks. No points were deducted.

Relevance dimension 4: Adaptability: response to change – scores **20 out of 20 points.**

Methodology for assessing relevance

Table 4: Methodology for assessing OECD DAC criterion: relevance

Relevance assessment dimensions	Basis for assessment	Evaluation design and empirical methods	Data quality and limitations
Alignment with policies and priorities	Extend of alignment with • BMZ Strategy on Transitional Development Assistance • The European Council Conclusions on operationalising the humanitarian-development nexus • Compliance with iPCA	**Evaluation design:** No specific evaluation design applied; the analysis follows the evaluation questions from the evaluation matrix **Empirical methods:** • Document analysis • Interviews	• Proposal and iPCA provide a solid sectoral background and context description of the project • Partner priorities were specified through interviews • Good evidence
Alignment with the needs and capacities of the beneficiaries and stakeholders	Alignment with the needs and capacities of • health care providers • health care managers • municipalities • alignment with the health needs of the population in the intervention sites • identification of connectors, dividers, security risks and their consideration	**Evaluation design:** No specific evaluation design applied; the analysis followed the evaluation questions from the evaluation matrix (Annex) **Empirical methods:** • Document analysis • Interviews • Chat & FGDs • Surveys • Inception workshop	• Project standard documents provided a sound basis to compare project approach with needs • Triangulation with humanitarian needs assessments and key informants • Risk monitoring for entire Cluster, project specific risk monitoring not updated since 2021 • Good evidence
Appropriateness of the design*	Extent to which the methodological approach proposals are a realistic and plausible pathway towards reaching the intended results	**Evaluation design:** Theory-based evaluation **Empirical methods:** • Document analysis • Detailed discussion of ToC during the Inception workshop with partners and project team	• Project standard documents sufficient for assessment • ToC and changes in the approach have been discussed extensively in the Inception workshop • Good evidence
Adaptability – response to change	Extent to which the project identified significant changes in the context and how the project responded to these changes based on the four official change proposals (see Table 2)	**Evaluation design:** Context and project mapping) **Empirical methods:** • Document analysis • Interviews • FGDs	• Standard project documents were triangulated with interviews • Strong evidence

* The project design encompasses the project's objective and ToC (GIZ results model, graphic illustration and narrative results hypotheses) with outputs, activities, instruments and results hypotheses as well as the implementation strategy (e.g. methodological approach, capacity development strategy).

Conflict sensitivity in the project design

Table 5: Dividers/escalating factors in the project context

Which escalating factors/dividers were identified in the project context?	Addressed by the project? (yes/no)	If addressed, how is it considered by the project design?
Support by the project could be perceived as preferring specific parties in the existing conflicts	Yes	Project ensured structured, evidence-based selection of intervention sites in close coordination with the local municipalities and used a phased approach increasing the number of included PHCCs from 7 to 25. An east coordinator mitigated risks associated with limited access and contact
Restrictions for women to access in various programmes	Yes	Considers needs of women, migrants and other disadvantaged groups in training and guidelines for service delivery. Creates favourable conditions for women to participate in activities
Xenophobia and discrimination towards migrants	Yes	Considers the specific needs of women, migrants and other disadvantaged groups in the training and guidelines for service delivery
Corruption or fraud related to procurement and distribution of goods	Yes	Corruption highlighted as an institutional risk in the project design. Project promoted transparent joint decision-making with partners

Table 6: Connectors/deescalating factors in the project context

Which deescalating factors/connectors were identified in the project context?	Addressed by the project? (yes/no)	If addressed, how is it considered by the project design?
Inclusive measures to build trust and reduce vulnerabilities of marginalised groups	Yes	Improved access to PHC to reduce vulnerabilities, inclusive municipal health management, inclusive trainings, community-based activities to bridge gap between communities and health facilities
Support the decentralisation of the health system to enable PHCCs to ensure sufficient needs-based service provision	Yes	With the modification proposals the project is increasingly emphasising management capacities
Reconstruction of public health infrastructure	Yes	The project design included improved the functionality of seven PHCCs
Indiscriminatory access to basic health services by ensuring proper funding	No	
Provide MHPSS measures to support individuals and communities	Yes	Added a new intervention area on MHPSS
Strengthening the national COVID-19 response	Yes	Provided protective equipment, equipment, training and mentoring for COVID-19 care in close coordination with the NCDC
Counter xenophobia and protect the rights of displaced people	No	
Address corruption through accountable and transparent financial systems	No	
Strengthen social cohesion fostering mutual understanding and cooperation	Yes	Supports inclusive local health working groups, facilitates exchange across all levels

4.3 Coherence

This section analyses and assesses the coherence of the project. It is structured according to the assessment dimensions in the GIZ project **evaluation matrix** (see Annex).

Summarising assessment and rating of coherence

Table 7: Rating of OECD DAC criterion: coherence

Criterion	Assessment dimension	Score and rating
Coherence	Internal coherence	48 out of 50 points
	External coherence	48 out of 50 points
Overall score and rating		Score: **96 out of 100 points** Rating: **Level 1: highly successful**

The project has been designed and implemented in a complementary manner within the German Development Cooperation. Strengthening PHC contributed to the stabilisation process in Libya. Municipalities supported by the project were selected among the projects supported by the Decentralisation project (PN 2018.2181.8) and multiple synergies have been achieved, for example rehabilitation of PHC facilities and strengthening the national COVID-19 response. The project coordinated with other technical cooperation (TC) projects through the structures of the GIZ Libya cluster and it was/is covered under regular coordination meetings between TC and financial cooperation (FC). Synergies with FC materialised especially during COVID 19. Internal coherence could have been even stronger, if more synergies in cooperation with other BMZ-funded agencies, e.g. Care, World Food Programme, Norwegian Refugee Council, had materialised. The project was consistent with international and national norms and standards through operationalisation of the humanitarian-development-peace nexus and contributing to the human right to health. The intervention's design and implementation has been coordinated with other donors' activities. Due to the context, existing systems and structures for monitoring, evaluation and learning (MEAL) were limited. Therefore, the project supported the roll-out of the Family Practice Approach and the health information system, which provide a reference framework and tools for national monitoring and learning systems. The project aimed to strengthen managerial capacity through a series of management workshops.

In total, the coherence of the project is rated as Level 1: highly successful, with 96 out of 100 points.

Analysis and assessment of coherence

Coherence dimension 1: Internal coherence

The assessment focuses on the extent to which the project has harnessed synergies for greater outcomes and efficiency gains within the GIZ Libya cluster and between FC and TC. The assessment follows the questions of the evaluation matrix (Annex).

GIZ has 'established a very well-structured cooperation with Libya, currently amounting to EUR 65 million in contract value. The core of the support is a BMZ programme co-financed by the EU to support decentralisation and municipal development as a contribution to peacebuilding in Libya. The programme supports approximately 30 municipalities along the migration route in establishing and strengthening local government and the provision of basic services' (German Embassy Tripoli, 2023, p.6). The project design and implementation reflect this perspective: the intervention sites were selected among those supported by the Decentralisation project, and there were synergies and cooperations with this project and its predecessor

‘Supporting Municipalities in Libya’ (PN 2016,2243.0). One example is the rehabilitation of PHCCs using the Decentralisation project’s budget line for construction and the technical assessment by the health project (Int 12, 14, 20 GIZ). Complementary measures funded by the Stud< and Expert Fund, for example the measure ‘Improving hospital hygiene’ and COVID-19 interventions, were also jointly coordinated. The project worked in synergy with other GIZ projects (e.g. conducting workshops for the Municipal Emergency Committees of 18 GIZ partner communities with the GIZ Governance Advisory Fund (PN 2017.2214.9)) to provide updates on the pandemic and on the interpretation of COVID-19 surveillance data. It actively engaged in the planning of the project ‘Socio-economic participation of vulnerable groups in Libyan municipalities’ (PN 2022.4048.9) and a bilateral health project ‘Strengthening the health system and pandemic prevention’ (PN 2021.2077.2). Further, the project attends GIZ Libya cluster coordination and monitoring meetings and contributes to the recently introduced digital monitoring tool. The tool is not yet fully functioning and has not yet been instrumental to foster coherence (FGD III: Int_12, 14 GIZ). BMZ also funds the World Food Programme and Care in Libya; however, the project is still considering potential synergies through cooperation with these organisations (Int_11 GIZ).

FC and TC interventions in Libya are meaningfully linked at the impact level (German Embassy Tripoli, 2023). Regular coordination meetings for all projects are held between GIZ and the KfW Development Bank, the project advisor is invited when health topics are discussed (Int_6 donor, Int_2, 11 GIZ). KfW contributed with other donors to the Stabilisation Facility for Libya,[14] various projects related to IDP and migrants[15] and COVID-19 vaccination.[16] These funds were channelled through UNICEF and the project had/has established working relations with UNICEF. During COVID-19, FC supported vaccination, while the project supported the municipal emergency coordination committees to set up the pandemic response (Peters, 2021c, 2022c; Int_9,11 GIZ; Int_6 donor). FC now funds the Norwegian Refugee Council for a new project ‘Strengthening the resilience of conflict-affected and vulnerable communities in Libya by supporting legal protection’ (BMZ Nr 20221841). The intervention areas overlap for Ajdabiya municipality. The FC project has no health components but focuses on legal support including support for access to basic services. This may be an opportunity to increase the project’s impact on improving access for migrants. So far, potential synergies have not been discussed (Int_6 donor, Int 11 GIZ). The original proposal does not refer to synergies with FC (GIZ, 2018), but the third modification proposal mentions synergies for the vaccination topic, mainly for the additional intervention area 3 on pandemic preparedness (GIZ 2021a).

The project is built on European and international norms and standards, namely the humanitarian-development-peace nexus to reflect the ‘New Way of Working’ agreed at the Humanitarian World Summit in 2016 [31.5.2018]. The project is designed and implemented with the do-no-harm principles (CDA, 2004) in mind. Examples were provided in Tables 5 and 6. The project is contributing to the human right to health.

In summary, the project complements other TC projects in Libya and it corresponds with the relevant norms and standards. FC and TC are coherent at the impact level, but synergies have not been sufficiently conceptualised in the design and are limited in practice. Therefore, 2 points were deducted.

Coherence dimension 1: Internal coherence – scores **48 out of 50 points**.

Coherence dimension 2: External coherence

This dimension explores how the project complemented and supported the partner's own efforts (principle of subsidiarity) while considering that the core mandate of a transitional assistance development project is

[14] BMZ Nr. 201668359 and 201841147.
[15] Perspectives for IDPs and Migrants in Libya (BMZ Nr. 201540822, Perspectives for IDPs and Migrants in Libya (BMZ Nr. 201640903); Perspectives for IDPs and Migrants in Libya (Phase IV) (201749936); Perspectives for IDPs and Migrants (Phase V) (202040822).
[16] Support to a safe, quality, and inclusive introduction of the COVID-19 vaccine in Libya (BMZ Nr. 202167377); Support to a safe, quality, and inclusive introduction of the COVID-19 vaccine in Libya (phase 2) (202267342).

different form a standard development cooperation project – the focus is more on the municipalities and less on higher political and strategic levels (see Relevance). The assessment is also based on how and how well the project coordinated and complemented activities with other development actors and the extent to which the project has geared its own MEAL efforts to strengthen the MEAL systems of the partners. The assessment follows the questions of the evaluation matrix (Annex).

In a fragile situation, projects typically need to balance immediate support for the population and the need to strengthen partner structures (Brinkerhoff, 2007; GIZ, 2015). Initially, the project has partially assumed the task of the partners, e.g. provision of medicines and de facto even provision of care (Int partner Int 1, 5 CSPS; IMC 2022b). However, this was done because the disrupted health system was not able to deliver PHC (ter Veen, 2017). In parallel, the project supported the municipalities to understand and implement national directives. It started in 2019 to foster a broad understanding of the Family Practice Approach and to support its gradual roll-out (see Relevance). It also introduced representatives from 13 partner municipalities to the national COVID-19 response plan and provided guidance on local adaptation of this plan (Peters, 2021c). As the project realised that it had not addressed underlying health systems issues and would therefore not help to build the resilience of the health system over time, it started to mobilise partner capacities differently. In June 2021, a workshop was held in Tripoli together with the PHCI, attended by district health managers and their representatives from then 11 partner municipalities. 'It was the first time that these groups had met in person' (Peters, 2022c, p.13). The aim of the workshop was to initiate a dialogue between the districts and PHCI and to set the stage for building their capacity to manage health services. After the suspension of project activities by ICO (see section 2.2), the workshops resumed in 2023. Stakeholders confirmed that the new approach was prompting some of the managers to assume their roles and responsibilities by simply clarifying these and giving orientation and simple tools to conduct managerial tasks (FGD II; Int 3, 4, 26 partner; Int 8, 16, 18, 21 GIZ; Hollmann, 2023). The project now strongly emphasises a resource-oriented approach to support partner's own efforts.

The project always aimed to use national guidelines for training purposes; however, guidelines were partly outdated or not applicable to the PHC setting. Therefore the project had submitted all training materials to the MoH for approval. Currently it supports PHCI to include updated guidelines in the PHC training package (Int 26 partner; Int 1–3, 6, 10 CSPS). Common systems for MEAL and accountability, which were applicable for the project, barely existed. As long as there was a health cluster, the project contributed to its health bulletins (FGD III). The project could have potentially supported the national HeRAMS (see section 3.1) but was explicitly asked by MoH not to do so (FGD III). Instead, it contributed to the countrywide roll-out of the DHIS2 by supporting training according to the national training plan and using the national training materials. Regular data entry would be a major change process within the current Libya health set-up (Int 4 donor; Int 2 partner; Giha, 2022). The project is now contributing to this change process by generating an interest in health management data through the management workshop series (Hollmann, 2023).

The selection of intervention sites was coordinated with other donor activities under guidance of the formal donor coordination structure at the time – the health cluster – which mainly looked at distributing the different partners to different municipalities to avoid overlap (Int 2, 4–5 donor; Int 26 partner; Int 1,5 CSPS, Int 8–9, 11, 17, 19 GIZ; Peters 2021c, 2022c; IMC 2022b). The project was an active member of the health cluster and the relevant working groups. Currently there is no formal donor coordination structure (Int 2, 5 donor), although some of the technical working groups continue, e.g. the MHPSS working group. Donors emphasise that the project shares their visions and aspirations for PHC (Int 2, 5 donor). Nevertheless, there is yet no formal cooperation or joint planning with other donors and/or their implementing partners for the project's landmark interventions (MHPSS FPs, competency-based training approach, management workshops).

In summary, the project pursued a resource-oriented approach to support partner's own efforts. It used existing structures as much as they existed and started to help building common structures for MEAL and accountability. There is yet no formal cooperation or joint planning with other donors and/or their implementing partners for the landmark interventions. Therefore 2 points were deducted.

Coherence dimension 2: External coherence – scores **48 out of 50 points.**

Methodology for assessing coherence

Table 8: Methodology for assessing OECD DAC criterion: coherence

Coherence: assessment dimensions	Basis for assessment	Evaluation design and empirical methods	Data quality and limitations
Internal coherence	The extent to which the project has harnessed synergies for greater outcomes and efficiency gains within the GIZ Libya cluster and between FC and TC	**Evaluation design:** Analysis follows the evaluation questions from the evaluation matrix **Empirical methods:** • Document analysis • Interviews	• Good documentation for all projects in the Libya Cluster plus the report of the German Embassy provide a strong data base. The documents were triangulated with a range of interviews • Evidence is strong
External coherence	The extent to which the project balanced immediate support for the population and the need to strengthen partner structures, coordinated with and complemented interventions by other development actors, realised synergies, and the extent to which the project geared MEAL efforts to strengthen systems and structures of the partners	**Evaluation design:** Analysis follows the evaluation questions from the evaluation matrix **Empirical methods:** • Document analysis • Interviews	• Assessment relies mainly on the project's own reports which were triangulated with a limited number of key informants (donors, GIZ and MoH) • Moderate evidence

4.4 Effectiveness

This section analyses and assesses the effectiveness of the project. It is structured according to the assessment dimensions in the GIZ project evaluation matrix (see Annex 1).

Summarising assessment and rating of effectiveness

Table 9: Rating of OECD DAC criterion: effectiveness

Criterion	Assessment dimension	Score and rating
Effectiveness	Achievement of the (intended) objectives	23 out of 30 points
	Contribution to achievement of objectives	18 out of 30 points
	Quality of implementation	15 out of 20 points
	Unintended results	19 out of 20 points
Overall score and rating		Score: **75 out of 100 points** Rating: Level 3: moderately successful

The project aims to improve PHC provision. Outcome indicators were partly achieved by May 2023. There are considerable risks for the full achievement of indicators by the end of the project associated with the challenges

of the Libyan health system. The project increased patient satisfaction by increasing functionality of seven PHCCs through direct support. The project has contributed to improved management practice through management workshops and staff competence by supporting PHCI to implement in-service training. Due to external factors (COVID-19, suspension of project activities by the ICO) and a change of strategy, the effect on PHC provision beyond the seven PHCCs remains to be seen. Through capacity development at individual, organisational and societal level, the project has contributed to increased awareness on MHPSS but there is not yet compelling evidence that this has also improved access to psychosocial support for disadvantaged groups. Participatory annual operational planning is a strong feature concerning the quality of implementation while RBM and management have weaknesses. The project captured unintended effects of project implementation and avoided any negative consequences through conflict-sensitive project implementation.

In total, the effectiveness of the project is rated Level 3: moderately successful, with 75 out of 100 points.

Analysis and assessment of effectiveness

Effectiveness dimension 1: Achievement of the (intended) objectives

The assessment is based on the objective indicators (Table 10) and the extent to which the project strengthened connectors (Table 6). The evaluators look at the current status *and* the likelihood of achieving the indicator by the end of the project.

Indicator 1: Satisfaction: Patient satisfaction **increased to 51% but fell short of the envisaged 70% target**. It seems unlikely that satisfaction will further improve because the direct support from IMC has ended and the effects of the indirect effect on patient satisfaction through management strengthening is expected to take longer. The indicator is **partly achieved** and is **not likely to improve further** before the end of the project.

Indicator 2: Guidelines: According to discussions with the project team and IMC during the inception phase, the indicator is meant to assess quality improvement: 'introduced' means that 25 PHCCs each implement two services according to the current PHCI guidelines. Based on data exchange via email during the evaluation, by 2022, **12 supported health facilities have each 'introduced' at least two new guidelines endorsed by the PHCI**. The project did not assess the actual adherence to guidelines during service delivery. Assessing adherence to the guidelines was beyond the scope of the evaluation. Instead, the evaluators asked project staff and implementing partners on their approaches, PHCC managers and staff on their experience[17] and PHCC managers on the services provided. The variety of answers suggests that the project has used guidelines as far as possible endorsed by PHCI, otherwise WHO guidelines. Clear reference to guidelines was made for mental health and non-communicable diseases (NCDs) (Albittar and Frerick, 2022, IMC, 2022b; Int_1 CSPS, Int_16 GIZ). At service delivery level, there is a willingness to use guidelines but there is still a lack of clarity, e.g. about which service guidelines are to be applied (Int_1,5, 8-14, 21, 23-24, 31 partner); and not all health staff has been trained (Int_1,5, 8-14, 21, 23-24, 31 partner). The following quote illustrates the overall impression 'We use different guidelines for the management and other guidelines for the medical services. Some are from the ministry, some from WHO and some we received during the training' (Int 5 partner). Considering

- that five of the supported PHCCs have staff who was trained to pass on their skills on the care pathways for NCDs in line with PHCI-approved national NCD standards (Albittar and Frerick, 2022)[18]

[17] Have new guidelines be introduced to you in the past years? Which ones? How many people were trained? Was there any mentoring or follow-up? By whom? How would you describe the results of the training in terms of skills of your staff and changes in service delivery?

[18] A total of 14 trainees hat completed the NCD pathway training successfully and became NCD training team candidates. Some of the trainees were also from hospitals, and some health centres had more than one successful participant. Therefore, the total number of health centres counted here is only five (Ghadamis PHCC in Ghadamis, Wadan in Al Jufra, Abduljalil in Janzour, Sidi Khalifa in Nalut, Al Kawassim Western in Al Zintan).

- that staff from PHCCs in eight supported municipalities received training and mentoring from IMC on WHO's mental health gap action programme (mhGAP), and
- Seven PHCC managers responding to the survey confirm that they provide NCD services and five confirm the provision of mental health services,

the evaluators estimate that the indicator is **partly achieved**. Assuming that training on the new PHCI guidelines based on the PHC training package currently developed will be rolled out effectively, the indicator **could be reached by the end of the project**. There are, however, great risks in terms of timely roll-out and the availability of staff and medicines in the facility, which would be necessary to implement the guidelines.

Indicator 3 (improved access to PHC): There are no survey or monitoring data available from the project. DHIS2 data on utilisation were not accessible for the evaluators. During the evaluation, key stakeholders and beneficiaries were asked if access has improved. The sample of respondents was not representative (by design of the interview process). Average agreement with the statement that access has improved was 58%[19] on a 4-point scale with the maximum value 99.9% across 11 district health managers who responded to the online Survey I and 79% across 16 PHCC managers who responded to Survey II. However, six PHCC managers stated that the improvement did not specifically benefit disadvantaged groups. To measure the indicator, the evaluators asked for examples of better access (Survey I, Chat II and the interviews with health representatives). In total there were **concrete examples for better access from seven municipalities** – better access due to presence of a doctor, more medicines, better qualified staff, new services. Based on the limited available data, the indicator for perceived improvement of access is currently **partly achieved**. It is expected that the project **will be able to fully achieve the indicator by the end of the project**. However, it should be noted that the indicator measures perceptions of individuals and is a weak proxy indicator for access.

Indicator 4 (**improved access to epidemic prevention**)**:** Monitoring or survey data to assess this indicator were not available. So far, the project had supported the COVID-19 response but no other epidemic prevention. The evaluators therefore asked about concrete examples for access to COVID-19 related services. Due to the scope and design of the evaluation, the sample of informants was not representative for all intervention sites. District health managers from **two municipalities gave examples, how barriers to access were addressed** – by setting priorities for the elderly, pregnant women and people with chronic diseases (Int 15 partner), and by treating migrants the same as local people (Int 7 partner). In addition, patients from the three visited areas confirm that they had access to information, advice, and vaccines at the primary level (Int 2, 5, 9 clients). However, the vast majority of clients interviewed reported that they or their relatives got tests and treatment in the private sector. A quick assessment done by IMC found that 'out of the 95 respondents who said that they or a family member needed COVID-19 services, 53 (56%) agreed that services are accessible and 57% of the respondents said that information relevant to COVID-19 was available' (IMC, 2022e, p.4). Based on the available data, the indicator is **partly achieved**. It is not possible to estimate the level of achievement by the end of the project, because the definition of what improved access to epidemic preparedness means beyond COVID-19 was not available at the time of the evaluation.[20]

Indicator 5 (**awareness on mental health issues**)**:** Monitoring or survey data to assess this indicator were not available. The evaluators used a survey, interviews and chats to assess the indicator. The average agreement with the statement that knowledge and/or attitudes towards psychosocial well-being and related needs have improved was 76% across 11 responding district health managers (Survey I). **In seven municipalities at least one respondent was able to provide an example** of how awareness on psychosocial well-being and related needs had increased. The examples included a positive reception of information on mental health within the

[19] Calculated based on 99,9% strong agreement, 66,6 agreement, 33,3% partial agreement: 0% disagreement

20 After the end of the evaluation, the evaluators received project progress report 4, the indicator was modified as follows: 60 members of the municipal emergency committees from 6 municipalities, 18 of whom are women, confirm the application of what they have learned to a relevant topic area of epidemic prevention in a practical example. The project envisages to pilot Event-based surveillance in cooperation with NCDC.

population (Int 7, 24 partner, Int 5, 9 CSPS, Chat I), increased support seeking for mental health (Int 8, 13, 18, 22, partner, Chat I), referral of patients from the community to the PHCC (Int 17 partner, Chat I), the presence of the MHPSS FPs (Chat I, Int 1, 6, 7, 9, 10, 18, 19, 22,24 partner) and approval of the MHPSS activities by the municipality (Int 7 partner). The indicator is **partly achieved**. It should be noted that the indicator measures only perceptions of individuals about awareness and does not measure access to MHPSS services. Given the current momentum, it is likely that the indicator can be **fully achieved by the end of the project**.

Connectors: A summary of potential connectors was presented in Table 6. The project has started to promote representation of vulnerable groups at the municipal level. It fostered friendships and acceptance between the different regions in Libya through joint training and workshops: 'We improved our skills after the training and also we made new friends from the other areas we are still in contact with them' (Int 23 partner). The project contributed to reduce stigma related to mental health issues (FGD II; Int 11,15–16 GIZ; Survey I, II; Chat I; IMC 2022d). In cooperation with the GIZ Decentralisation project, the project contributed to the reconstruction of public health infrastructure (see Coherence) and to improved public service provision (see outcome indicators). It has strengthened the national COVID-19 response and supported selected health facilities so that they could maintain and even improve services provision despite the pandemic. The project was highly successful in strengthening connectors within the small scale of the selected intervention areas (see Impact).

Table 10: Assessed and adapted objective indicators (outcome level)

Project's objective indicator according to the (last change) offer	**Assessment according to SMART* criteria**	**Specified objective indicator** (only if necessary for measurement or understanding)
1. Out of 1000 interviewed clients (600 women) of the PHCCs supported by the project, 70% of men and 70% of women rate the services proposed as good or very good Base value (2019 west, 2021 east): 43% (38% woman, 49% men) (across all facilities) **Target value** (8–10/ 2024): 70% **Current value** (2021 West, 2022 East): 51% (50% women, 53% men) **Achievement in %** (2021 west, 2022 east date): 73 **Source:** Exit interviews by IMC, values calculated using final raw data sent by project 9 May 2023	**S**: The indicator is specific for the seven PHCCS that received direct support by IMC **M**: With some challenges: It was not possible to interview 1000 people within the budget and time frame for the surveys that were conducted by IMC on behalf of the project **A**: Unlikely **R**: Rating by clients can be used as a proxy for confidence in health services **T**: Measurement a) at the end of IMC support (2022) and b) 2024	
2. 25 PHCCs have each introduced 2 additional clinical guidelines and protocols to standardises the quality of services relevant to disadvantaged groups **Base value**: 0, according to SARA (ter Veen, 2017) low availability of guidelines before the project **Target value** (12/2024): 25 **Current value** (12/2021): 12/25 **Achievement in %** (05/2023): 48 **Source**: email from project (6/2023)	**S**: During inception discussion it was specified that 'introduced' means guidelines approved by the PHCI will be applied during service provision **M**: Yes **A**: Possible with high risk **R**: Yes, to measure the application of guidelines **T**: Yes, but no milestones to track progress	
3. In 11 municipalities, 70% of 44 spokespersons performing the role	**S**: Yes, improved access is the removal of barriers identified in the	*This modification is a proxy indicator for evaluation purposes only*.[21]

[21] There is no monitoring data for this indicator. Identifying and interviewing the required number of spokespersons was beyond the scope of the evaluation. For the evaluation purpose only, it was agreed in the inception phase to explore whether in 70% of the now

Project's objective indicator according to the (last change) offer	**Assessment according to SMART* criteria**	**Specified objective indicator** (only if necessary for measurement or understanding)
of multiplicators for vulnerable groups confirm, based on examples, that access to **PHC services** has improved for disadvantaged groups. **Base value:** 0 spokespersons; the factors that impede access to PHC were described in the needs assessments **Target value** (March 2025): 70% **Current value:** No data, data will not be available before end 2023. **Achievement in** %: Not known Source: to be determined	needs assessment **M:** Yes, provided that 44 spokespersons are clearly identified. **A**: Likely **R**: The indicator is a weak proxy indicator for better access. **T**: Yes, but no milestones to track progress towards achievement.	3. In 8 of 12 municipalities respondents[22] confirm, based on examples, that access to PHC services has improved for disadvantaged groups. **Base value**: Barriers to access: language barriers, gender norms, long waiting hours, stigmatisation and a general lack of services. **Target value**: 8 municipalities **Current value** (05/ 2023): 7 **Achievement in %:** 87 **Source**: Evaluation interviews, Survey, Chat II
4. In 4 municipalities, 16 spokespersons performing the role of multiplicators for disadvantaged groups confirm, based on one example, that access to **epidemic prevention** has improved for disadvantaged groups **Base value:** 0; assessment at the beginning of COVID-19 showed no specific measures **Target value** (12/2024): 70% **Current value:** no data available, assessment planned for end 2023 **Achievement in %** not known **Source:** to be determined	**S:** Unclear what access to epidemic prevention entails, this will be detailed during the operational planning in June 2023 **M:** Yes, if spokespersons are identified and access to epidemic prevention is explained **A**: Unclear, until it is detailed what access to epidemic prevention will mean beyond COVID-19 **R:** to some degree: access should better be measured by utilisation and coverage data **T**: Yes, but no milestones to track progress towards achievement	*This modification is a proxy indicator for evaluation purposes only*.[23] 4. In 4 of the 12 supported municipalities, respondents[24] confirm, based on one example, that access barriers to vaccination, including COVID-19 testing or treatment for disadvantaged groups have been mitigated **Base value**: The following access barriers have been identified: language barriers, not knowing where to go, stigma **Target value** (12/2024): 4 **Current value** (05/2023): 2 **Achievement in %:** 50 **Source**: Evaluation interviews
5. In 11 municipalities, 70% of the 44 interviewed local providers of psychosocial support and representatives of vulnerable population groups confirm, based on one example, that awareness on psychosocial well-being and related needs has increased at the municipal level **Base value:** 0 **Target value** (12/2024): 70% **Current value** (4/2023): No data available now and not expected to be ready for the evaluation Achievement in % (4/2023): not known **Source**: to be determined	**S**: Unclear, how the 44 local providers and representatives are identified. 'Awareness' is vague **M:** It is unclear how the indicator will be measured in detail, i.e. which examples qualify to indicate success **A**: Likely **R:** The indicator is used as a proxy for a reduction of socio-cultural access barriers. It is not sufficient to objectively assess stigma **T: Yes**	*This modification is a proxy indicator for evaluation purposes only.*[25] In 8 of 12 municipalities, respondents[26] provide one example, that knowledge and/or attitude towards psychosocial well-being and related needs has improved in the municipality **Base value** (August 2022): In a KAP study, over 70% of interviewees demonstrate limited knowledge and discriminatory attitudes **Target value**: 8 **Current value** (May 2023): 7 **Achievement in %:** 88 **Source**: Evaluation interviews, Chat I, II

12 supported municipalities, evaluation participants would be able to provide examples in order to estimate whether the project is on track or not.

[22] Health Representatives, spokespersons of vulnerable groups, mayors, district health managers, PHCC staff.

[23] There is no monitoring data for this indicator. Identifying and interviewing the required number of spokespersons was beyond the scope of the evaluation. For the evaluation purpose only, it was agreed in the inception phase to explore whether in four municipalities, evaluation participants would be able to provide examples in order to estimate whether the project is on track or not.

[24] District health managers.

[25] There is no monitoring data for this indicator. Identifying and interviewing the required number of local providers of psychosocial support and representatives of vulnerable population groups was beyond the scope of the evaluation. For the evaluation purpose only, it was agreed in the inception phase to explore whether in 70% of the now 12 supported municipalities, evaluation participants would be able to provide examples in order to estimate whether the project is on track or not.

[26] Health representatives, spokespersons of vulnerable groups, MHPSS FPs, mayors, district health managers, PHCC staff.

Project's objective indicator according to the (last change) offer	Assessment according to SMART* criteria	Specified objective indicator (only if necessary for measurement or understanding)

* SMART: specific, measurable, achievable, relevant and time-bound

In summary, all five project objective indicators were partly achieved; 3 points were deducted for indicator 1 because it is not expected that it will increase by the end of the project. In contrast, indicators 2–5 may or may not be achieved by the end of the project depending on risk management of the project; 3 points were deducted for the high risk of not achieving indicator 2 and one point because of the limited clarity and the resulting risk of not achieving indicator 4. No points were deducted for indicators 3 and 5 because it is expected that they will be achieved by the end of the project. All points are achieved in view of strengthening connectors. Effectiveness dimension 1: Achievement of the (intended) objectives – **scores 23 out of 30 points.**

Effectiveness dimension 2: Contribution to achievement of objectives

This dimension explores whether and how the project's activities and outputs contributed/will contribute to the outcome results as visualised in Figure 2. The assessments focus on the four results hypotheses in Table 11. They were selected jointly with the project team and partners using the following criteria:

- Covers a central aspect of the project.
- Is very relevant for the development of the PHC system in Libya.
- Provides insight into the project, its success, and the main challenges.
- Is evaluable, that is, a reasonable amount of data can be collected during the evaluation.

The outputs that were part of the initial proposal are achieved or are on track:

- The functionality score of seven PHCCs has increased on average by 18.3% at seven PHCCs. This means that the PHCCs significantly improved the preconditions for PHC service delivery including organisation, competencies, medicines, and equipment (Peters, 2023a, b; EXCEL tables with the complete assessment data provided by the project).
- At least 12 out of now 26 PHCCs provide on average four essential health services (Peters 2023a, b).
- 82% out of 67 employees who received training on NCD pathways demonstrated improved competences by comparing pre- and post-test results (Peters, 2023a, b).
- 11 male and 31 female PHCC doctors have received a training of trainers certificate (Peters, 2023a; Albittar and Frerick, 2022) of these 36% (15 persons) carried out an orientation at their PHCC within four months after completion of the training of trainers course. All of them were women (Peters, 2023a, b).

There was limited data for output indicators in the two newer intervention areas, but activities are being implemented:

- The project provided testing equipment, training and mentoring and protective equipment which likely increased access to testing and treatment.
- The project trained and mentored the municipal emergency teams during the COVID-19 pandemic.
- The project trained volunteers on psychosocial first aid and provided a training of trainers to enable selected persons to multiply competencies for psychosocial first aid in the communities, in 7 out of 12 municipalities, MHPSS FPs have implemented one measure each to strengthen psychosocial support services.
- 28 MHPSS FPs (48% women) from 11 of the project's partner communities, are networked online and actively exchange ideas.

Results Hypothesis 1: 12 PHCCs spread across eight municipalities were supported through training, provision of medical and non-medical commodities, equipment and rehabilitation. Seven PHCCs[27] had on-site mentoring teams, who were directly involved in service provision (IMC, 2022). The approach was 'quite unique' at the time (Int 1 CSPS) and carefully coordinated to avoid overlap or duplication (Int 1 CSPS; Inception workshop; Int 3, 26 partner, Int 5 donor, Peters, 2020a, 2021c, 2022c). 'IMC had very significant support to the clinic, they helped the patient in diagnosis and providing medicines, many patients had diabetes, hypertension and heart diseases were following up with doctors here and receiving the medication' (Int 5 partner). At the end of support, the functionality score of seven PHCCs has increased on average by 18.3%. Services that were not available prior to the intervention became available. Partners reported significant increase in utilisation rates and appreciated the support, namely the provision of medicines but said that it was limited and only for selected services (Int 5, 7, 15, 17, 19, 20 partner). One interviewee said that the Family Practice Approach brought a new system of delivering care based on need and in closer collaboration with the communities (Int_ 14 CSPS). Patients highlighted the availability of doctors and services (gynaecological care and diabetes treatment were repeatedly mentioned), medicines for free, better organisation. Based on interviews with patients, service providers and managers, the project made a difference: 'The PHCC [name deleted] has improved very well and moved to another level after they were provided with some devices, medicines and the doctors from IMC. The village now is very happy. But the other PHCCs did not receive good support' (Int 20 partner). One centre declared that it was functional without project support but through the support of local businessmen (Int 25 partner). IMC confirms that it was able to overcome obstacles to procurement due to local knowledge and networks and thereby minimised delays. In conclusion, the project has contributed tangibly to better service delivery during the time the mentoring teams were on site, and medicaments were available. **The hypothesis is confirmed**. The project was able to avoid major delays in deployment of staff and goods. Most PHCCs would not have been able to reach the level of performance without project support. However, it was part of the success, that the mentoring team partly replaced staff that was not available.

Results Hypothesis 2: The project initiated a series of management workshops for multidisciplinary teams and in groups encompassing several districts each (Hollmann, 2023). Average confirmation for the need to improve own management skills was 96% on a 4-point scale with the maximum value 99.9% across 16 PHCC managers who responded to Survey II. The average agreement with the statement that their municipality has the ability to plan, manage, direct and obtain resources to provide PHC was only 39% across 11 district health managers who responded to the online Survey I. These findings confirm that the project definitely responded to a need when focusing on management training. There is, however, no evidence for concrete changes resulting from this training. It may be too early for this. Yet, there are indications that participants appreciated the workshops, felt motivated and started to think differently about their roles and responsibilities (Int 5, 7, 15–17, 19, 21, 23 partner, Int 17 GIZ). One PHCC manager said, 'There are no changes yet, but I had new connections and we have a WhatsApp group where we discuss and plan' (Int 19 partner). Managers are willing to participate or to delegate participation within their team (FGD I & II, Int partner). The project team reports a growing interest even beyond the supported municipalities and improving participation (Int 8, 15, 16, 19, 21 GIZ). District health managers think that communication has improved. The evaluation Survey I found 76% average agreement with better communication between health authorities and municipalities and between the district health management and the PHCCs and 70% average agreement that communication between the district and the central level has improved across 11 district health managers. However, an important tendency voiced was that local management cannot ensure service delivery unless external partners or the MoH provide sufficient resources for PHC. Managers, staff and patients expressed concerns that service delivery cannot be improved without external support: 'We have plans and we are willing to train [staff] and improve the services and the capacity of all PHCC, but we don't have financial resources. The ministry didn't pay us in the past two years, we cannot do anything' (Int 7 partner). **The hypothesis can only be partly confirmed**, the assumption

[27] Polyclinic Garabuli, Abduljalil Martyrs (Janzour), Sidi Khalifa (Nalut), Al Kawassim Western (Zintan), Tamahant (Wadi Al Bawanis), Elshahid M. Eddora (Adjdabya), Brega Eljadeda (Brega).

that managers (or their deputies) are willing to engage is fully confirmed; however, political/administrative barriers delayed implementation. Alternative explanations have been excluded (the Decentralisation project was not directly supporting health planning), travel barriers for women were overcome by covering additional travel costs for accompanying persons (GIZ, 2021a). MoH was not deploying trained health managers.

Results hypothesis 3: PCI has developed a PHC in-service training plan, a monitoring and evaluation data collection tool for PHCI and is currently preparing the competence-based training modules (PCI, 2022a). There was a focal person for this project in the PHCI. 'She has been able to ensure the commitment and engagement of key stakeholders; provide advisory input to all aspects of the project ensuring that all deliverables are aligned to MoH priorities and to the context' (ibid., p.8). PHCI has expressed full commitment to the roll-out of the training (Inception workshop). It was unclear, however, how exactly the training of the PHC workers will be rolled out and how the risks (insufficient provision of equipment, consumables, medicines) to implement training content will be addressed. The risk of inadequate selection and management of trainees is addressed during the management workshops (see hypothesis 2). No other donor implemented a similar approach. Partners already expressed interest to use the modules and to support the PHC training plan (Int 2, 5 donor). Interviewees confirmed that PHC providers have very limited access to training and that the use of national guidelines is also very limited (see outcome indicator 2 above). It is plausible that the training – once it is rolled out – will contribute to the functional, technical and administrative competencies of the PHCC staff; however, it is too early to observe concrete results at outcome level. The hypothesis is **partly confirmed**.

Results hypothesis 4: The project has identified male and female MHPSS FPs and trained them as trainers for psychosocial first aid (PFA). FPs are doctors and other professionals. Most of them already had mental health training, mainly using mhGAP. After the training, participants were assessed to be ready as trainers or co-trainers, or not yet ready to be. Every FP developed his/her personal development plan (IMC, 2022d). The FPs engaged in awareness raising at the community level and within health facilities, some of them participated in the implementation of a study on knowledge attitude and practice (KAP) regarding MHPSS and conducted PFA training at various levels (GIZ, 2023c, Peters, 2023b, Int_ 16 GIZ; FGD I, II). The KAP study indicated that there was still a huge need for information and advocacy for MHPSS. FPs felt confident that they can pass on their knowledge. Some reported that a lack of logistic support prevented them from doing so (Chat I). FPs and PHC staff knew about each other, sometimes FPs worked directly in PHCCs. The project supported networking between the FPs and experts and between each other, for example, by printing brochures with names, numbers, and workplaces of FPs and experts. Two FPs said that without the project MHPSS would not exist. They emphasised that the project worked to facilitate many important matters at all levels, whether logistical, organisational or technical (ibid.). FPs said that they maintained contact with the psychologists who trained them to take advice in any situation that calls for referral (ibid.). While some respondents underline big improvements in referral (ibid., Int 17, 25 partner), others report that they face problems (Int 19, 21, 23 partner): 'people who need MHPSS are going through many difficulties: reaching a psychiatrist, the limitations of the specialist, and the long distance and also the doctors' lack of interest in this vital aspect at the primary level' (Chat I). As discussed for outcome indicator 5, the project certainly contributed to awareness about mental health. However, a variety of partners including UNICEF, IOM, the humanitarian organisation INTERSOS and a broad range of local partners have already promoted awareness on MHPSS since several years (Awidat, 2023). It is difficult for the evaluators to differentiate the effect of the project from the effect of other interveners. Patients interviewed for the evaluation did not mention experiences with FPs and do not know about local structures to take care of mental health problems. Some interviewees explain how PFA has helped to understand and support persons with mental health issues instead of blaming or stigmatising them (Chat I). At the national level there it is still discussed which type of care and medication should be provided for mental health at PHCC level (Int 16, 22 GIZ). The **hypothesis is partly confirmed**.

Table 11: Selected results hypotheses for effectiveness

Results hypothesis 1 (activity – output – project objective)	Tailor-made support to seven PHCCs (**A1**) would have increased their functionality (**R1**). This would be a precondition for improved PHC service provision (**OP A**) in terms of delivering a broader range of services according to clinical guidelines (**R7**) and improved PHC provision in terms of availability and quality (**project objective**).
Main assumption	The required support (equipment, personnel and medicines) would reach the PHCCs without major delays.
Risks/unintended results	Limited availability of PHCC staff, a general lack of motivation and accountability, challenges with procurement and distribution of material and security issues.
Alternative explanation	PHCCs had received the necessary inputs for basic service delivery from other sources.
Confirmed/partly confirmed/not confirmed	Results hypothesis 1 is confirmed.
Results hypothesis 2 (activity – output – project objective)	Workshops, training and coaching (**A2**) would enable local health managers to adopt new management routines (**R3**). These routines are expected to include the establishment and functioning of inclusive health working groups to plan and steer PHC services according to local needs (**R4**). This would also be a precondition for improved PHC provision at the municipal level (OP A) in terms of a broader range of quality services (**R7**) and more effective referral (**R8**) as two equally important elements of quality and access but also underline the orientation towards social cohesion (**project objective**).
Main assumption	Health managers are willing and able to participate in the management workshops and to implement the solutions that are developed during the workshops.
Risks/unintended results	Political and administrative obstacles which prevent the project from working as planned. In addition, a lack of interest to adopt and/or support new managerial behaviours and practises as well as socio-cultural barriers, including stigmatisation, fear and travel barriers for women which may negatively affect representation of vulnerable groups in the planning and steering processes.
Alternative explanation	Deployment of well-trained health managers or intensive management training through other actors would enable the managers to work better. The efforts of the GIZ Decentralisation project would also cover the establishment and mentoring of health working groups. Other partners or the government would continue to provide full support to the PHCCs so that local management would not be needed to ensure adequate service delivery.
Confirmed/partly confirmed/not confirmed	Results hypothesis 2 is partly confirmed.
Results hypothesis 3 (activity – output – project objective)	If the PHCI uses the PHC training package and the pool of trainers developed by the project (**A4**) to conduct standardised PHC in-service training (**R5**), the functional, technical and administrative competencies of the PHCC staff will be improved (**OP B**). This would be a third precondition for the extension of the range of services according to standard clinic guidelines (**R7**) as one element of improved PHC provision with regard to quality and access (**project objective***).*
Main assumption	MoH will fully endorse the training.
Risks/unintended results	Funds and management capacities will not suffice to ensure the provision of infrastructure, consumables, and medicines to implement the content of the training. Another risk is that human resource management capacities will be insufficient to ensure that trained staff will stay in charge for the services s/he has been trained for.
Alternative explanation	Other actors would provide sufficient PHC training. Increased accountability, performance, performance-based pay and exposure to international resources would encourage PHCC staff to upgrade their skills individually and provide services in line with clinical guidelines. Sufficient newly trained staff with the required competence would replace older staff and reduce the need for in-service training.

Confirmed/partly confirmed/not confirmed	Results hypothesis 3 is partly confirmed.
Results hypothesis 4 (activity – output – project objective)	Thanks to training and mentoring (**A8**), community FPs will have basic knowledge and skills regarding MHPSS (**R13)**. This would enable them to engage in MHPSS activities and pass on their skills (**R14**) and also to engage in a functioning MHPSS network which effectively links communities to the PHCCs where basic mental health care would have been established through the project's support activities (**R15**). This would lead to improved access to community-based psychosocial support for disadvantaged groups (**OP D**) and an important new element of PHC provision with regard to access and an orientation towards social cohesion (**project objective**).
Main assumption	Enough volunteers can be mobilised to assume the FP function.
Risks/unintended results	Main risks are that doctors will not be allowed to provide mental health services in the PHCCs and that there is a lack of higher-level services to which patients can be referred for specialised MHPSS. Another **risk** is stigmatisation of persons with mental health issues.
Alternative explanation	Social media and national campaigns would reach the communities and increase the demand for MHPSS services without the community multipliers fostered by the project.
Confirmed/partly confirmed/not confirmed	Results hypothesis 4 is partly confirmed.

Factors influencing outcome achievement: The grant agreement with IMC was a key success factor for the project in achieving functionality of PHCCs and also in implementing COVID-19 measures because the NGO was able to operate on the ground despite conflict and could manage the logistics thanks to local networks and experience on the ground. In interviews, the project and IMC[28] underlined the high quality of their partnership, which enabled swift responses in the dynamic environment. The second success factor was the local team of advisors who were bridging the gap between the remote management team and the beneficiaries. Thanks to the permanent communication of the local team with partners and between the local team and the remote advisors and because of the participatory annual planning processes, the project was able to learn and adjust the intervention strategies. Other success factors have already been discussed under Relevance and Coherence. Internal factors for partial or non-achievement of outcomes were the trade-offs between addressing systemic issues and direct support to the target group. The choice of rather complex interventions in the volatile environment engendered high risks for the achievement of objectives. Operational challenges due to security, the pandemic and the suspension of the project by ICO (see section 2.2) delayed the achievement of objectives. Insufficient funding of PHC in Libya and slow recovery of the health system with dysfunctions in all building blocks[29] are framework conditions that limited the effectiveness of training.

In summary, result hypothesis 1 was fully confirmed. Results hypotheses 2 to 4 were partly confirmed. The confirmation of a plausible project contribution reaches until the use of output level, but there was at best anecdotal evidence that the use of output has indeed contributed to the desired outcomes. Therefore, 4 points were deducted for each of the hypotheses 2 to 4. It is expected that the contribution of the project to the outcome may be more tangible by the end of the project because the time of implementation was too short.

Effectiveness dimension 2: Contribution to achievement of objectives – scores **18 out of 30 points.**

[28] The interview codes are not mentioned to maintain anonymity.
[29] Service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance (WHO, 2010).

Effectiveness dimension 3: Quality of implementation

This dimension assesses the extent to which the quality of implementation contributed to the success of the project. The analysis considers the Capacity WORKS success factors.[30]

The project steering structure was based on the implementation agreement 2019; no agreements were signed to cover the changes of the four modification offers (GIZ, 2022a). During annual planning sessions, the project agreed with partners on milestones and the mode of cooperation. Quarterly technical meetings between MoH and the project were planned but could not always happen, for example during the pandemic. Meetings on technical issues and meetings with ICO happened as required. Partners appreciated the participatory approach and technical quality of the meetings (Int 26 partner; Inception workshop). Operational plans, meeting protocols, and an updated stakeholder map were available to the evaluators. The capacity development strategy reflected the dilemmas of capacity development in the fragile context (GIZ, 2022c). Partner interaction was strongly focused on PHCI and NCDC, other departments in the MoH were less involved with project steering (Int 11, 22 GIZ; Int 3, 4, 17, 26 partner). At the time of the evaluation, the project had appointed a communication officer but was still defining communication objectives and adequate messages and channels. Initially the project had started to set up a results-based monitoring system. Monitoring efforts included collection of quantitative and qualitative data using systematic capacity assessments, patient satisfaction surveys and partner interviews (KOMPASS). However, the project lacked clear definitions of most indicators and their measurement. It did not use proxy indicators to track progress of indicators. Risk monitoring has been discontinued. The risks related to the increasingly complex intervention design were not formulated and tracked. This led on one hand to iterative and partly redundant monitoring through implementation partners and on the other hand to very limited availability of data for decision-making, accountability and learning (FGD III; Int 11, 13, 15, 23 GIZ, Int 1, 5 CSPS; Peters 2020a, 2021c, 2022c, 2023b). Staff fluctuation in the ministry affected the continuity of communication and joint decision-making. ICO suspended the project to work (see section 2.2) and deployment of equipment purchased under the COVID-19 measures was not done as planned originally (Inception workshop). After the end of the humanitarian health cluster, the MoH did not provide a formal coordination structure for international partners (Int 1, 2, 5 donor).

In summary, the annual operational planning was a functioning and appreciated steering mechanism. Gaps in the RBM system and risk monitoring limited the quality of steering. Therefore, 5 points were deducted.

Effectiveness dimension 3: Quality of implementation – scores **15 out of 20 points.**

[30] Capacity WORKS is the management model of GIZ. Success Factors are strategy, cooperation, steering structure, processes and learning and innovation.

Photo 1: Introductory session in a training workshop *(© GIZ, 2022)*



Effectiveness dimension 4: Unintended results

In this dimension it was assessed to what degree unintended results at output and outcome levels have been observed/can be anticipated and how the project monitored such unintended effects and responded to them. It was also discussed if/how the project applied conflict-sensitive project management and monitoring.

Based on the gender analysis (Schulz, 2021), the project may have inadvertently reinforced gender stereotypes which restrict women's participation, for example through a lack of female representation in the trainings and workshops. The project anticipated this risk and mitigated it by ensuring a secure environment for all training (Int 11, 15 GIZ) and other measures (see dimension 2). Since the beginning of the project, 2,014[31] PHCC staff have been trained; the proportion of women is 57% (Peters, 2023b). The project's influence on female participation at the steering level was limited because relevant positions in the MoH were mainly assumed by men. Based on the evaluation interviews (see Sustainability), the project may have inadvertently contributed to the perception that PHC delivery depends on external support. The project counteracts this unintended effect through management workshops (Hollmann, 2023; GIZ, 2022c). The effect that inviting trainees from different regions of Libya helped to build trust across the different political divides was initially unintended. Based on feedback from the participants, the project adopted the mix of participants as a strategy for all training in view of fostering social cohesion (FGD I). Potential dividers were derived from the iPCA (GIZ, 2021b) and the project took measures to not strengthen these dividers (see Table 5). According to project reports, the listed measures were implemented as planned. There are no indications that dividers were strengthened. However, the project had limited influence on the distribution of goods procured during the COVID-19 pandemic (Inception workshop, Int 11, 22 GIZ). The project had no formal continuous monitoring of unintended effects but kept closed contact with partners through the local advisor team. It has used qualitative interviews (KOMPASS) twice which would have eventually captured unintended affects.

In summary the project anticipated and managed unintended effects adequately. There was no formal and continuous monitoring of unintended effects but the use of KOMPASS and mainly close communication at all

[31] Double counting is possible, because one person may have attended several trainings.

levels enabled the project to capture unintended effects and avoid strengthening of dividers. Therefore, only one point was deducted.

Effectiveness dimension 4: Unintended results – scores **19 out of 20 points.**

Methodology for assessing effectiveness

Table 12: Methodology for assessing OECD DAC criterion: effectiveness

Effectiveness: assessment dimensions	Basis for assessment	Evaluation design and empirical methods	Data quality and limitations
Achievement of the (intended) objectives	Extent to which the project • Objective was achieved (based on the achievement of the objective indicators) (see Table 11) with a critical consideration of the specificity and relevance of these indicators • Was able to strengthen connectors/weaken dividers	**Evaluation design:** Analysis follows the evaluation questions from the evaluation matrix **Empirical methods:** • Document and secondary data analysis • Interviews • FGD and chat groups • Online surveys	• Limited monitoring data • Secondary data scarce • Method and stakeholder triangulation possible • High number of key informants; however only anecdotal evidence • Moderate evidence
Contribution to achievement of objectives	The extent to which it is plausible that the project's activities and outputs contributed to/will contribute to the achievement of outcome results, looking at the results hypotheses in Table 11	**Evaluation design:** Contribution analysis: This design consists of a 'specific analysis undertaken to provide information on the contribution of a program to the outcomes' (Mayne, 199, p.6). It is chosen to understand how and why PHC provision in Libya has been improved by the project. **Empirical methods:** • Document analysis • Interviews • Online survey • FGDs and chat groups • Inception and debriefing workshop	• Hypothesis 1: Triangulation of implementer reports with interviews • Hypothesis 2: information on workshops but limited evidence on management practice • Hypothesis 3: Activity is not fully implemented, evidence on output and indication on use of output, not on outcome • Hypothesis 4: good triangulation of reports, chat groups and interviews • Moderate evidence
Quality of implementation	The extent to which the quality of implementation contributed to the success of the project	**Evaluation design:** Analysis follows the evaluation questions from the evaluation matrix. **Empirical methods:** • Document analysis • Interviews • FGDs • Inception workshop	• Risk of self-serving answers was managed through triangulation of perspectives and methods • Good evidence
Unintended results	Extent to which • Unintended results at output and outcome levels were observed and how the project responded • conflict-sensitive management and monitoring at the outcome level were applied	**Evaluation design:** Verifying assumptions of unintended results in an iterative manner and outcome harvesting **Empirical methods:** • Document analysis • Interviews • FGDs	• Anticipated unintended results from Gender analysis, iPCA and inception interviews discussed, unintended effects explored during interviews and FGD • Good evidence
* SMART: specific, measurable, achievable, relevant and time-bound			

4.5 Impact

This section analyses and assesses the impact of the project. It is structured according to the assessment dimensions in the GIZ project evaluation matrix (see Annex 1).

Summarising assessment and rating of impact

Table 13: Rating of OECD DAC criterion: impact

Criterion	Assessment dimension	Score and rating
Impact	Higher-level (intended) development changes/results	23 out of 30 points
	Contribution to higher-level (intended) development results/changes	28 out of 40 points
	Contribution to higher-level (unintended) development results/changes	30 out of 30 points
Impact score and rating		Score: **81 out of 100 points** Rating: Level 2: successful

At the impact level, the project aimed to contribute to UHC and peaceful stabilisation. The United Nations, World Bank and the European Union support Libya in this sense. The MoH is working on preconditions for a more strategic allocation of funds. The Ministry of Local Government has approved a roadmap towards empowering municipalities to take a more important role in public service provision. WHO emphasises that investments in PHC improve equity and access, health care performance, accountability of health systems, and health outcomes. Within these dynamics it seemed likely that the project-related higher-level development objectives can be achieved. However, a functioning PHC system starting from Libya's troubled health system is a long-term endeavour. Current policies have a limited focus on the LNOB promise of the SDG agenda and gender equity. The political will in the volatile context remains a high risk. The project was not designed to accompany the process over the longer-term. Impact therefore depended on the ability of the project to convince and support national and international partners to pursue and scale up project initiatives. The project could therefore have had more impact if it focused more on the dissemination of its initiatives, results and lessons learnt. **In total, the impact of the project is rated Level 2: successful, with 81 out of 100 points.**

Analysis and assessment of impact

Impact dimension 1: Higher-level (intended) development changes/results

Dimension 1 examines the extent to which project-related higher-level changes could be observed or foreseen.

At first sight, the context for achieving the project-related higher-level changes seems challenging: 'The world is moving at only about one quarter of the pace needed to reach the SDG targets by 2030' (WHO, 2022, p.1). Libya's health system was not only disrupted due to the conflict but also due to the COVID-19 pandemic. However, international support by WHO, World Bank and EU have a strong focus on UHC in the context of the humanitarian-development-peacebuilding nexus and the UN Sustainable Development Cooperation Framework (UNSDCF) 2023–25. This makes it likely that Libya will pursue UHC to achieve SDG 3 over the long term. UHC strengthens the right to health and reduces the risk of catastrophic expenditure for health care. This is important for the poorest and most vulnerable part of the population and will contribute to LNOB and also to ending poverty (SDG 1), increasing gender equity (SDG 5) and reducing inequalities (SDG 10). Yet, health care providers and managers may not be aware or dispute the need to remove access barriers for selected groups (see Relevance). Therefore, substantial groundwork would be required to devise and

implement targeted action. The MoH currently makes gradual progress in defining an essential health services package. So far, costing scenarios have been prepared and decisions are pending. They will depend on political decisions over the next decade rather than on the principal availability of financial resources in Libya (MoH, 2023, Int 4 CSPS, Int 26 partner, see also observations on the economic context in section 2.1). Regarding peace, stability, and strong institutions (SDG 16), there is a positive dynamic towards decentralisation with participatory and inclusive approaches to decision-making at the municipality level (Int 12, 14, 20 GIZ; Int 1, 2 donor; German Embassy Tripoli, 2023). The Ministry of Local Government has approved a roadmap towards empowering municipalities (GIZ Decentralisation project, 2022). However, literature indicates a risk that Libyan women's and girls' needs and priorities will be shut out of recovery efforts due to a rollback on gender equality (Irhiam, 2023). Because SDG 16 and gender equity are so interwoven, there is a risk that inadequate representation of women may jeopardise the achievement of peace and stability.

In summary, it seemed likely that the project-related higher-level development objectives can be achieved. However, the political will in the volatile context remains a high risk, therefore 5 points were deducted, and 2 points were deducted because current policies have a limited focus on LNOB and gender equity.

Impact dimension 1: Higher-level (intended) development changes/results – scores **23 out of 30 points.**

Impact dimension 2: Contribution to higher-level (intended) development results/changes

This dimension explores the extent to which it is plausible that the project's outcome contribute to/will contribute to the achievement of related higher-level development goals as visualised in Figure 2. The assessments focus on the two results hypotheses in Table 14 which have been selected jointly with project team and partners.

Hypothesis 1: If the project improves PHC service provision, the effectiveness and efficiency of health services will increase so that a precondition for UHC is established. This hypothesis is in line with current thinking as summarised by WHO: 'Across the world, investments in PHC improve equity and access, health care performance, accountability of health systems, and health outcomes' (WHO, 2021). In Libya this is particularly true because historically the health system was focusing on hospital care rather than on a network of local service providers. Resource allocation was/is not linked 'to delivering a strategic health services package, resulting in over- and under-supply, substantial geographic inequities and inefficiencies across the country' (MoH, 2023 p.2). According to the MNSA, 33% of households report having member(s) who needed, but were unable, to access health care in the 30 days prior to data collection (REACH, 2023). Being more able to meet the most prevalent health needs of the population at the local level and through PHC and effective referral mechanisms is therefore a very plausible contribution to more efficient and effective health care. However, the contribution of the project towards UHC is very limited in scale. It would have been tangible if the experience of the project had informed national strategy development and if approaches and instruments of the project were scaled up by the MoH and other partners. Supporting the Family Practice Approach as the PHC service delivery model was a good choice in view of scalability because it has been selected by the MoH and is supported by WHO. Teaching and training materials are already owned by the PHCI (Inception workshop, Int 3, 6 CSPS). The Family Practice Approach is understood and endorsed at the municipal level (Int 8, 19 GIZ). One municipal health representative said, 'The Family Practice Approach removes barriers to access PHCCs'. On the other hand, the project's documentation of lessons learnt and strategic communication to encourage scaling-up were very limited (FGD I, II, see also Effectiveness, dimension 3). Therefore, the **hypothesis can be only partly confirmed**.

Hypothesis 2: If PHC provision is oriented towards social cohesion and communication between actors and administrative levels is increased, there will be more trust in and accountability for health service delivery which would serve as a connector and contribute to peace. The hypothesis is in line with international thinking: 'Strengthening mutual trust between the state and the citizenry and among communities is considered essential to build resilience and achieve durable peace and stability, especially in conflict-affected regions and countries and/or fragile, violence-affected settings' (UNDP, 2022). As demonstrated under Effectiveness

dimension 2, project staff observed, and project partners confirmed, improved communication across the levels within the municipality and to a lesser degree between the municipalities and the central level. The evaluation surveys found an average 85% level of agreement with the statement that 'PHC services play an important role in achieving peace and stability in our region' across 11 responding district health managers and 16 PHCC managers. The evaluators consider the involvement of vulnerable groups in health-related decision-making as an important element of improved communication to which the project has most likely contributed:

- 8 out of 11 key informants for vulnerable groups have participated in meetings at the municipal level where decisions on health were made; they assess the capacity of their municipality to include representatives of vulnerable groups in decision-making positively but not yet fully developed. One informant said after participating in a GIZ workshop, 'After we explain the idea in the municipalities, the involvement of the vulnerable groups may be excellent, and this depends on us' (Chat II).
- 5 out of 6 interviewed municipal health representatives provided at least one example for involvement of vulnerable groups.[32] The examples included participation of representatives of women, elderly and young people in formal meetings of the municipality (e.g. planning and review of local development plans) and informal meetings and discussions, involvement of (unspecified) vulnerable groups in training programmes, facilitation of physical access of people with disabilities to municipal meetings.

If patient satisfaction is a dimension of trust in public health service delivery, the assessment of Effectiveness indicated that trust depended and will depend on the permanent availability of (free) medicines, doctors and services. Therefore the project had contributed to trust temporarily but may have weakened the trust by ending the direct support. **The result hypothesis can only be partly confirmed.**

Table 14: Selected results hypotheses for impact

Hypothesis 1 (project objective – impact)	If PHC service provision is improved in terms of better quality and accessibility (**project objective**) health services in Libya would become more efficient and effective (**I1**). This is a precondition for UHC (**I2**).
Main assumption	Political processes will evolve towards stabilisation. Reconstruction of the disrupted health sector in Libya remains a priority of the Libyan authorities and international partners. Adequate health financing mechanisms are introduced.
Risks	Necessary policies and strategies for health system development towards UHC will not be developed and endorsed by the Libyan authorities. Funding and implementation of the policies and strategies remain inadequate.
Alternative explanation	UHC will be achieved through another health service delivery model than the current PHC approach.
Confirmed/partly confirmed/not confirmed	Hypothesis 1 is partly confirmed.
Hypothesis 2 (project objective – impact)	If PHC provision is oriented towards social cohesion (**project objective**), communication between actors is increased and the disconnect between administrative levels decreased (**R18**), this would contribute to increased trust in and accountability for health service delivery (**R19**) which would serve as a connector and contribute to peace (**I3**).
Main assumption	Political processes will evolve towards stabilisation and the authorities maintain a focus on equity.
Risks	Conflicts cannot be resolved or escalate. The current level of service delivery cannot be maintained or degrades further.

[32] The term ‚vulnerable' was not predefined by the evaluators, representatives consider young people, elderly, the poor, people with disabilities, non-Libyans and people with lack of means of transport as vulnerable

Alternative explanation	Social cohesion and the disconnect between actors and administrative levels is more effectively addressed through legislation and effective decentralisation than through PHC.
Confirmed/partly confirmed/not confirmed	Hypothesis 2 is partly confirmed.

Factors of impact achievement: Thanks to its unique approaches and the strong focus on the humanitarian-development nexus, the project was instrumental in initiating the gradual changes which would not have happened without the project or if the project had continued to keep its focus on the more humanitarian approach of direct service delivery without addressing health systems issues. However, the project's ambition to improve service provision via better management may yield results only in the mid to long term and would most likely require sustained support. Therefore scale-up through national or international partners would be a prerequisite for impact in the mid to long term, that is after the end of the project (see Sustainability). Within its mandate, the project focused on the municipal level. Leverage at the policy level was a 'side-effect' of the good project management (see Effectiveness) rather than part of its mandate. Limited guidance and coordination of international partners by MoH (Int 2, 5 donor, Int 11, 22 GIZ, Int 26, 31 partner, Int 4, 7 CSPS) and the 'overall weak policy and systems environment' (AESA Consortium 2022, p.45) made it difficult to federate the efforts of all partners towards the higher development goals. Nevertheless, the evaluators believe that the project could have achieved more impact by showcasing approaches and effects on the basis of a more elaborate MEAL and communication system to compel international partners and by including more departments in the MoH to broaden the range of national partners involved with the project.

In summary, the contribution to higher development goals is plausible with a long-term perspective. The impact hypotheses are only partly confirmed; therefore 10 points were deducted. The project contributed to structural changes which are steppingstones for a long-term impact. It has not yet sufficiently developed and communicated its models for scale-up. Therefore 2 more points were deducted.

Impact dimension 2: Contribution to higher-level (intended) development results/changes – scores **28 out of 40 points**.

Photo 2: Certification of trainers *(© GIZ, 2022)*



Impact dimension 3: Contribution to higher-level (unintended) development results/changes

It is likely that people with chronic diseases who experienced free medicines and care during the time of IMC support may fall back to high out-of-pocket expenditure, which indicates the dependence on external support but not an effect of the project. The project has identified this issue and has developed approaches to decrease dependency through better management. The project has anticipated risk for unintended effects in terms of gender equity and has addressed these as part of the capacity development strategy (see Relevance and Effectiveness). All interventions were discussed and agreed upon with the national partners prior to implementation to avoid escalating dividers or exposing project and partner staff to conflict. No unintended project-related higher development changes were identified.

In summary, the project took precautions to avoid unintended negative effects and strengthened connectors. No points were deducted.

Impact dimension 3: Contribution to higher-level (unintended) development results/changes – scores **30 out of 30 points**.

Methodology for assessing impact

Table 15: Methodology for assessing OECD DAC criterion: impact

Impact: assessment dimensions	Basis for assessment	Evaluation design and empirical methods	Data quality and limitations
Higher-level (intended) development changes/results	Extent to which project-related higher-level changes could be observed or foreseen in terms of SDGs and policy markers for gender equity, Governance, poverty and peace, LNOB and trade-offs between concrete support with a direct effect for the population and structural support	**Evaluation design:** No specific evaluation design applied; the analysis follows the evaluation questions from the evaluation matrix **Empirical methods:** • Document analysis • Secondary data analysis • Interviews	• No statistical data or forecasts on UHC and gender equity • Only indicative data triangulated with limited expert views • Political development and speed of peace process cannot be assessed • Weak evidence
Contribution to higher-level (intended) development results/changes	Extent to which the contribution of the project to higher development changes can be identified based on two selected results hypotheses from project objective to impact level as specified in Table 14	**Evaluation design:** Contribution analysis **Empirical methods:** • Document analysis • Interviews • FGD	• Assumptions in the impact logic can only be substantiated anecdotal evidence • Views and interpretations are subjective, this was partly mitigated through a triangulation of sources and methods • Moderate evidence
Contribution to higher-level (unintended) development results/changes	Whether • Unintended development changes have been observed and the extent to which the project contributed and responded to these • Dividers and connectors have been identified and weakened/strengthened	**Evaluation design:** Outcome harvesting applied at impact level **Empirical methods:** • Document analysis • Interviews • FGD • Chat	• No information on unintended higher-level changes through interviews and FGD • Assessment only based on document review by evaluators • Weak evidence

4.6 Efficiency

This section analyses and assesses the efficiency of the project. It is structured according to the assessment dimensions in the GIZ project evaluation matrix (see Annex 1).

Summarising assessment and rating of efficiency

Table 16: Rating of OECD DAC criterion: efficiency

Criterion	Assessment dimension	Score and rating
Efficiency	Production efficiency (resources/outputs)	50 out of 70 points
	Allocation efficiency (resources/outcome)	21 out of 30 points
Efficiency score and rating		Score: **71 out of 100 points** Rating: **Level 3: moderately successful**

The project was able to absorb funds through implementation of planned activities and to contain costs despite the challenging context. The transformation of inputs to outputs was successful for improving PHC provision at the municipal level and improving access to community-based psychosocial-support services. It was limited regarding the development of PHC workers' competence and pandemic preparedness. This was mainly due to delays in implementation and deployment of procured goods. The project had limited options to achieve its objectives in the given context. In addition, operationalising the humanitarian-development nexus would always require learning loops in project implementation – and learning comes with a cost. Investment in a stronger MEAL system to track progress towards outcome and linking costs to indicators might have helped to limit costs which did not contribute to outcomes. A more systematic approach to training from the beginning would most likely have maximised results in the area of competence development. Refraining from procuring hospital equipment would have saved considerable resources without affecting outcome achievement.

In total, the efficiency of the project is rated Level 3: moderately successful, with 71 out of 100 points.

Analysis and assessment of efficiency

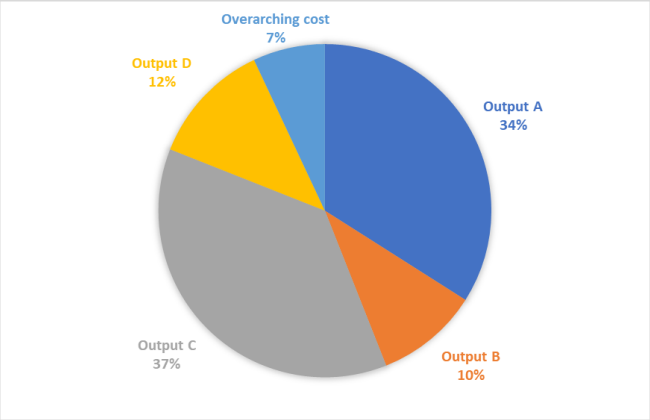
Efficiency dimension 1: Production efficiency

Dimension 1 describes the costs per output and explores whether a) the costs per output were appropriate for the achieved results at output level, b) whether outputs were and could have been maximised with the given resources and c) whether costs per output were and could have been minimised while achieving the same outputs. It is assessed whether costs per output and actual output indicator achievement were monitored and considered together for decision-making. As per GIZ requirements the evaluators used the GIZ efficiency tool.

Figure 4: Efficiency tool: overall costs and achievements per module indicator (screenshot)

	Output A	Output B	Output C	Output D	Overarching costs
Outputs	The functionality of PHCCs is improved, particularly with regard to the provision of services to vulnerable groups	The functional, technical and administrative competences of the PHCC staff are improved.	Epidemic preparedness is strenghtened in selected municipalities.	Access to community-based psychosocial support services is imporved for vulnerable populations	
Costs incl. commitment (Obligo	4.910.620,25 €	1.425.253,29 €	5.446.777,30 €	1.741.039,60 €	1.057.622,23 €
Co-financing	0,00 €	0,00 €	0,00 €	0,00 €	0,00 €
Partner inputs	76.526,45 €	76.526,45 €	32.797,05 €	32.797,05 €	0,00 €
Total costs	**4.987.146,70 €**	**1.501.779,74 €**	**5.479.574,35 €**	**1.773.836,65 €**	**1.057.622,23 €**
Total costs in %	**34%**	**10%**	**37%**	**12%**	**7%**
BMZ total costs in % without co-financing	**34%**	**10%**	**37%**	**12%**	**7%**
Plan for residual funds (residual value)	0,00 €	0,00 €	0,00 €	0,00 €	

Figure 5: Efficiency tool: total costs per output and overarching cost in %

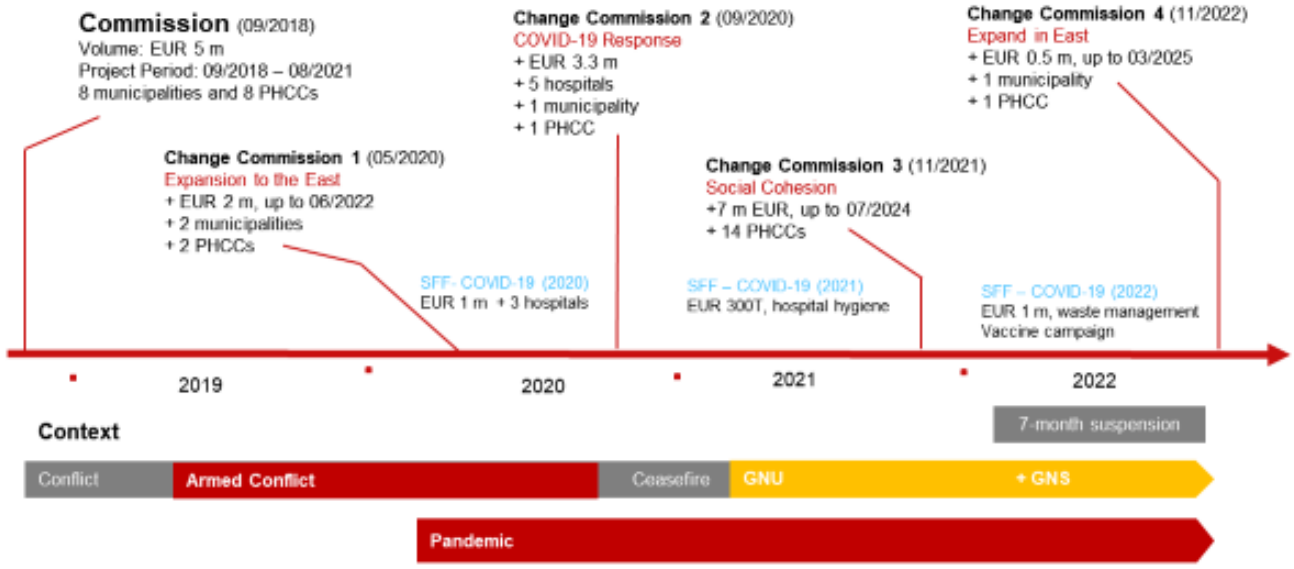


As shown in Figure 4, **outputs A and C** absorbed 71% of the total project cost. Cost for output A stemmed mainly from the contracts with IMC (68% of the value of all grants), procurement of medicines and equipment to increase the functionality of PHCCs and costs for human capacity development including the contribution to the national roll-out of DHIS2. Costs under output C include costs for local procurement and most importantly the procurement of hospital and laboratory equipment that was purchased as part of the COVID-19 response. It constituted 84% of all equipment purchased by GIZ headquarters. Costs also include a consultancy contract for an online course on hospitals asset management. Costs under **output B** included mainly the grant agreement with PCI for the PHC training plan and modules and the largest proportion (60%) of all consultancy contracts especially for the development of online courses on NCDs and community health workers. The main costs under **output D** were for personnel and human capacity development as well as a smaller grant with IMC for MHPSS (including the training on PFA). Costs for personnel were distributed quite evenly across the outputs, with the lowest cost for output A. **Overarching cost** was only at 7% and includes cluster related cost, e.g. the contribution to the cluster monitoring tool, cluster workshops but also COVID-19 tests, costs of the GIZ office including the risk management office and a proportion of personnel cost that cannot be attributed to the outcomes. The cost was comparatively low. For example, a recently evaluated GIZ project from Libya stated that 11% was low considering security costs (Hamkens, 2021). Partner contributions included office space, the daily allowances for MoH officers to participate in project steering and the continued payment of salaries of health workers and managers during their absence from work for participation in training and events. Some 70% of partner cost cover output 1 and 2 with 30% remaining for outputs C and D. There were no deviations from planned allocation. However, it is worth noting that the project budget has been constantly adjusted through new incoming funds in line with the modification offers as depicted in Figure 6.

By the time of the interim evaluation, the level of achievement per output is as follows:

- Output A: 92%
- Output B: 14% (The achievement is delayed due to a change in strategy where the project switched from providing individual training to an advisory process which will enable PHCI to cascade training based on standardised modules, see Effectiveness)
- Output C: 0% (no data has been collected and the project switched the focus from COVID-19 to event-based surveillance)
- Output D: 58% (as shown in Figure 6, the activities have started in in 2021 and were affected by the 7-months' suspension of activities, more details on this in Relevance and Coherence)

Figure 6: BMZ commissions – timeline (Peters, 2023c)



There are no available benchmarks to assess whether costs could have been minimised. However, GIZ has salary and procurement standards to which the project complied. It is therefore assumed that costs could not have been minimised. The number and qualification of staff seem predominantly adequate considering the remote management situation. The time needed for remote management and communication including translation was factored into the personnel strategy. The project has also invested in building the team's capacity to strengthen their competence as advisors (Int 17 GIZ). Project staff explained that costs for Libya are higher than in other countries because of security issues (e.g. only expensive hotels meet security criteria, national project staff cannot be employed by GIZ but through an agent operating in Libya). Also, rules and regulations for procurement exclude all Libyan firms who cannot follow the required procedures in English. This reduces competition and therefore leads to high prices. Overall, the distribution of funds across outputs was plausible, considering the substantial cost of equipment and medicines that were only procured for these two outputs. During COVID-19, the equipment planned for selected hospitals arrived late and was then not dispatched by MoH as previously agreed. In consequence, expenditure did not contribute to the achievement of output C as planned. On one hand, all health organisations faced the problem of delays during the pandemic; and on the other hand the project had limited room for manoeuvre due to the fragile context (see Effectiveness). The evaluators considered whether instead of procuring hospital equipment further investment in other outputs would have been more efficient. Theoretically, the project could have used the funds for hospital equipment to maintain/increase the functionality of more than five additional PHCCs to ensure that basic service provision would be kept up during the pandemic and to overachieve the planned targets for the indicators. This may have been more efficient in terms of allocation efficiency (see below). It may also have improved production efficiency if equipment for PHCCs could have been purchased at the local market saving overhead and transaction costs (Int 1, 5 CSPS, Int 19, 21 GIZ). However, the evaluators could not obtain

sufficient data to confirm that local procurement would have been possible on a larger scale at the time. It is also questionable whether adequate implementation partners could have been mobilised for additional grant agreements and whether the conflict-sensitive selection of health facilities would have been possible under so much pressure.

For output B, costs appeared to be high in relation to output even though the proportion of the cost was low: considering that only 15 master trainers[33] had passed on their knowledge to other health workers following an online training on NCDs (Albittar and Frerick, 2022), production efficiency appeared to be low. While the ambition of the NCD training was different from that given by IMC, the actual result justifies the question whether the same result might been achieved under the IMC grant without or with minimal additional cost. The project decision to switch from individual training towards a more systemic approach was well-justified based on this experience but to date has not had positive effects on production efficiency because outputs are still incomplete. Depending on whether the roll-out of the training modules developed under the PCI grant will or will not be completed by the end of the project, production efficiency is likely to increase/decrease. Another online course (community health workers) was not used and therefore did not contribute to the outputs. It seems as if the development of online courses was not efficient. But it should be considered that remote (digital) training was the only way to continue training during COVID-19 and would a priori also be a cost-effective method to bring up-to-date knowledge to the health workers in Libya. However, the acceptance of digital learning was extremely low and would have required more efforts to increase digital literacy and to develop and design training approaches that increase adherence (Int 11, 15–17 GIZ; Int 2–3, 6, 10 CSPS; Albittar and Frerick, 2022, PCI, 2022a, b). The training package by PCI will not include digital formats (PCI, 2022a).

The project kept good control over their overall budget despite the repeated additional funds, it managed to integrate funds of the Study and Expert Fund into the overall management of the project and increased financial leverage through cooperation with other GIZ projects especially, but not only, in view of facing the COVID-19 pandemic (Int 4, 6, 2, 10,11, see Coherence). However, it did not formally monitor cost per output and actual output indicator and was therefore less well equipped to use financial monitoring data for participatory data-driven decision-making.

In summary, the project was able to absorb and control the funds despite the fragile context and its aggravation during COVID-19. The transformation of inputs to outputs was good for outputs A and D but not good for outputs B and C. The project made limited use of financial and monitoring data for steering towards more efficiency: 20 points were deducted for the limited efficiency regarding outputs B and C and the limited use of financial monitoring data.

Efficiency dimension 1: Production efficiency – scores **50 out of 70 points**.

Efficiency dimension 2: Allocation efficiency

Allocation efficiency asks if outcomes could have been maximised with the given resources and whether cost could have been minimised while achieving the same outcome. The evaluators were also interested whether the costs were monitored versus the achievement of objective indicators and considered for decision-making.

In the fragile context, the project had limited options. It needed a partner with experience and access on the ground. Improved access could have been achieved by relying entirely on this organisation. However, realisation of the humanitarian-development nexus required a more development-oriented approach which the project could best realise with the current blend of national and international advisors and expert organisations. As face-to-face meetings became impossible with COVID-19, the project also did not have other options than

[33] 60 practitioners were enrolled in the training, 42 met the requirements and were certified and only 15 oriented their fellow staff after completion of the training.

to develop digital options. The use of the Moodle-based learning platform atingi was less costly than the development of a dedicated platform. However, other platforms may have been more user-friendly and/or more accessible for management by Libyan partners. The project may also have resorted to more specialised and potentially more costly providers of online learning who have specific experience with digital capacity building like Jhpiego, who have handled online learning successfully using a 'hub and spoke network', for example in the project 'Training of professionals in the health sector' (2016.2086.3) in Ethiopia (Dagoye, 2022). However, this may have engendered other issues in view of product ownership, scalability and cost.

The project could have spent less for identification of intervention sights, capacity development and travel cost to achieve concrete results with a more limited geographical focus. However, this would have involved trade-offs in terms of its social cohesion ambition and may have strengthened dividers (see Table 5). To operationalise the humanitarian-development nexus the project had to continuously readjust to balance the partly conflicting need for concrete support to the population and the development of partner structures. Managing the 'dilemma' (GIZ, 2015) of capacity building in fragile settings would always require learning loops in project implementation and such loops come with a cost. Therefore no points were deducted for costs of strategy change. However, throughout the evaluation it became evident that challenges regarding the MEAL system affected success for all criteria. The project might have saved money if the RBM had supported a better result-orientation in managing and steering the project. In addition, it must be asked whether the project outcomes could have been achieved without any procurement of hospital equipment.

If the project had invested in a systematic training approach from the beginning, the first results might have been achieved by now. Resources used for individual trainings could have been used for the roll-out of the integrated training plan (see Effectiveness). This would have left more time for follow-up and thereby enhanced the chance that providers would adopt and apply the new competences. It might even have enabled IMC to use their grant better. A narrow focus on one or two training topics may have maximised positive results in terms of competence compared to the now proposed eight in-service training modules plus management module.

In summary, the project had limited options to achieve its objectives due to the context. However, investment in a stronger MEAL system might have helped to limit costs which did not contribute to outcomes. A more systematic approach to capacity development from the beginning would most likely have maximised results in the area of competence development and refraining from procuring hospital equipment would have saved considerable resources without affecting outcome achievement. Therefore 3 points are deducted for each of those three gaps.

Efficiency dimension 2: Allocation efficiency – scores **21 out of 30 points**.

Methodology for assessing efficiency

Table 17: Methodology for assessing OECD DAC criterion: efficiency

Efficiency: assessment dimensions	Basis for assessment	Evaluation design and empirical methods	Data quality and limitations
Production efficiency (input/outputs)	Description of the data: Costs per output, type of costs, agreed and provided partner contributions, using GIZ efficiency tool, and the extent to which inputs have been transformed into outputs	**Evaluation design:** Follow-the-money approach and analytical questions from the evaluation matrix (see Annex) **Empirical methods:** • Document and cost analysis (using GIZ efficiency tool) • Interviews • Inception discussion	• Retrospective estimation of costs per output • Limited evidence for assessing the achievement of outcome and output indicators • Benchmarking data was barely available (only one recent evaluation from Libya published with limited financial data) • Moderate evidence
Allocation efficiency (input/outcome)	Extent to which • The outcome was/could have been maximised with the given resources and project costs were/could have been minimised • The costs vs achievement of module objective indicators were monitored and considered together for decision-making	**Evaluation design:** No specific design, the analysis follows the analytical questions from the evaluation matrix based on the GIZ efficiency tool **Empirical methods:** • Document analysis • Interviews	• Based on effectiveness assessment • no comparison with similar projects and no financial benchmarks • Moderate evidence

4.7 Sustainability

This section analyses and assesses the sustainability of the project. It is structured according to the assessment dimensions in the GIZ project evaluation matrix (see Annex 1).

Summarising assessment and rating of sustainability

Table 18: Rating of OECD DAC criterion: sustainability

Criterion	Assessment dimension	Score and rating
Sustainability	Capacities of the beneficiaries and stakeholders	15 out of 20 points
	Contribution to supporting sustainable capacities	23 out of 30 points
	Durability of results over time	38 out of 50 points
Sustainability score and rating		Score: **76 out of 100 points** Rating: Level 3: moderately successful

Beneficiaries and stakeholders of the project had resources to sustain positive results. However, underfunding of PHC, the lack of medicines and a threatening lack of resources for systematic in-service training and quality assurance were bottlenecks in view of sustaining improved PHC provision. The project has helped to increase

capacity and resilience through training and material support but mainly by fostering networks. In addition, the project promoted resilience in terms of pandemic preparedness. Capacity development at the municipal level aimed at mobilising local resources and capacities. Early achievements towards capacity for PHC provision at the municipal level and the networks of health managers, health providers and MHPSS focal points are likely to be durable to some extent. However, the political and peacebuilding landscape remains fragile. Therefore multiple risks for sustainability persist. The project has not yet done enough to address the risks and to mobilise resources for continuous in-service training. Project achievements towards community-based psychosocial-support services are still facing obstacles before institutionalisation, but the project contributed to momentum that will be pursued by other national and international actors.

In total, the sustainability of the project is rated Level 3: moderately successful, with 76 out of 100 points.

Analysis and assessment of sustainability

Sustainability dimension 1: Capacities of the beneficiaries and stakeholders

Dimension 1 explores if the capacity, resources, ownership, and resilience of beneficiaries and stakeholders to sustain the results achieved. 'Results' are the current level of achievement of indicators.

According to United Nations Office for the Coordination of Humanitarian Affairs (OCHA) the humanitarian situation has improved but vulnerabilities still exist, and it is estimated that 4% of the population will continue to require humanitarian assistance in 2023. The economic power to ensure transport and to purchase medicines and needed services from private providers when they are not available in the public sector is limited for at least one third of the population (see Impact). Patient interviews indicated that patients are willing to use their PHCC when doctors and medicines are available. It is expected that municipalities will play an increasing role in PHC (see Impact). The project trained representatives from the local health authorities, as well as the managers of the supported PHCCs based on the Family Practice Approach. However, the capacity development strategy was not based on a detailed capacity assessment of the municipality in terms of their competence to manage and steer health care (GIZ, 2022c). Health representatives said that their capacity to plan, manage and steer has improved after they participated in management workshops and that the situation was constantly improving, nevertheless they also underlined that they still lack resources and technical support to further develop the PHCCs (Int 11–16 CSPS). District health managers saw the capacity at municipal level less optimistic. The average level of agreement with the statement 'our municipality has the ability to plan, manage, direct and obtain resources to provide primary health care' was only 39% across 11 respondents (Survey I). Other partners underlined the lack of financial resources (Int 7, 15–17, 19, 20 partner); the fluctuation of personnel (Int 7 partner); insufficient infrastructure and the lack of doctors (Int 16 partner). However, there are also examples of capacity and a willingness to share and shine: 'Other PHCCs can learn from how we work on the Electrocardiograph' (Int 17 partner). The general tendency of the views can be illustrated by one respondent's words: 'I think after the training and support we are now ready to operate on a high level. And the capacity of the administration and medical staff has improved. All we need is some support from the government. We lack medicines and doctors, and this can only be from the government' (Int 21 partner). The capacity for MHPSS is rather limited in the Libyan health system, the main challenge is the lack of specialised care to refer cases outside the large cities (see Effectiveness). While MHPSS FPs felt confident about their capacity to pass on their knowledge, the lack of time and means of transport limits their capacity to sustain the positive effect without external support (Chat I). Only a few PHCCs apply mhGAP.

At the central level, the technical capacity of PHCI and NCDC were highly appreciated, a new accreditation agency holds promise for more standardisation and quality in health care (Int 11 GIZ; Int 1,3, 5, 6 CSPS, Int_26, 30, 31 partner). However, the overall organisation and lack of clarity regarding roles, responsibilities and decision-making power do not allow the system to function well. Overall, Libya's health sector is under

extreme stress but there are opportunities to strengthen the health system (Irhiam, 2023; MoH 2023, see also Impact). In view of implementing PHC in-service training, the PHCI has demonstrated clear ownership and it has a list of potential trainers (Inception workshop; PCI, 2022a). However, it is currently unclear whether the necessary financial resources will be available to roll out the training.

In summary, beneficiaries/stakeholders have some resources to sustain positive results and to resist external shocks. However, underfunding of PHC, the lack of medicines and a probable lack of funds for systematic in-service training and quality assurance are important bottlenecks. Therefore 5 points are deducted.

Sustainability dimension 1: Capacities of the beneficiaries and stakeholders – scores **15 out of 20 points.**

Photo 3: MHPSS focal points and project staff *(© GIZ, 2022)*



Sustainability dimension 2: Contribution to supporting sustainable capacities

This dimension assesses the project's contribution to the partner's capacity to sustain the results.

The project has provided mentorship and technical training, and this has helped health providers to introduce new services (output) and to improve the quality of care (outcome) (see Effectiveness). Five trainers have also passed their knowledge on to others (see Effectiveness). Training has enabled MHPSS FPs to identify individuals who need mental health care and to share their knowledge at various levels (see Effectiveness). At the central level, the project enhanced the capacity of PHCI to provide planned in-service PHC training. It is going to train a pool of trainers (PCI 2021a, b, 2022 a, b). A series of management workshops has started to enable managers from the different municipalities, districts and PHCCs to make more use of the scarce resources, for example by better selection of trainees and workshop participants (FGD II). The project hopes to enable managers to increase resources at their disposition through better planning and communication with the central level. 'We want to teach them how to fish' (FGD II). FGD participants saw indications that partners started to think more carefully what they can do with what they have and what they need in addition. The annual operational plannings were also used to bring local concerns to the attention of the central level (FGD II). Capacity development at the municipal level aimed to increase local resilience to external shocks (FGD II). The project has helped actors to understand national health policies and to adapt them to their local reality. The project encouraged the setting up of health teams at the municipal level but had no clear plan on how these should engage with local development planning and resource allocation processes (ibid.).

The project integrated an activity area 'pandemic preparedness' (output C) with the original design. During COVID-19, it supported the municipal emergency committees and helped to equip and capacitate biosafety

laboratories (Peters, 2023b). It is now starting to pilot event-based surveillance and thereby hopes to contribute to increased resilience in view of pandemics.

Networks, cooperation and peer learning were supported across all intervention areas. Throughout this report we have discussed that the project has not yet fully operationalised specific approaches in favour of vulnerable groups, but new and promising activities have been started. The project strives to identify and empower vulnerable groups by linking them to networks and fostering networking as a basis for participation and representation e.g. in the municipal health teams.

In summary, the project's exit strategy relied/relies on networking and support to effective decentralisation. The aspect of resource mobilisation and specific intervention to increase the resilience of particularly disadvantaged groups remain to be strengthened. Therefore 7 points are deducted.

Sustainability dimension 2: Contribution to supporting sustainable capacities – scores **23 out of 30 points**.

Sustainability dimension 3: Durability of results over time

The assessment is based on the discussion of factors that will determine the durability of results over time and tries to make a justified prognosis of the durability. 'Results' are the changes that have been measured with the outcome and output indicators as discussed under Effectiveness.

The political and peacebuilding landscape remains fragile (OCHA, 2022). The main challenges are fragmentation of health sector institutions; weak governance and accountability; extreme shortages of medical supplies and health staff; a disrupted PHC network; and funding shortages (ibid.). Positive trends regarding decentralisation described under Impact and the networks described in dimension 2 can increase the resilience of the municipal health systems and support the durability of positive achievements. The presence of international donors in the health sector and the broad consensus on UHC are stabilising factors (see Impact).

The project did not have any negative effects (see Effectiveness and Impact). Durability for the four outputs and related outcomes was assessed as follows:

- Improved PHC provision at municipal level (output A): Functionality of PHCCs is likely to decrease once the medicines procured by the project and the motivation of staff through ongoing support come to an end. 'The support from IMC was very helpful for us, they provided some devices, medical materials and medicines. This allowed us to operate very well for some time. The patients could find the medicine and no need to buy, especially the old and poor people. It helped the staff to improve their knowledge and capacity, and on the other hand they have more confidence and trust. And there is more trust between the medical staff and the community. The effect after the support ended is very clear, we don't have enough medicine, utilisation is very low, and we operate very slow' (Int 23 partner). If decentralisation will progress, municipalities will be able to mitigate the constraints in the mid-term perspective, if the project uses the remaining time to establish a sound capacity development plan for the communities and agrees with a suitable partner, namely the Decentralisation project, to pursue this plan. From the evaluation, there is no clear indication whether or not the management workshop series will evolve into a networking platform that can continue to support peer learning after the end of the project.
- Improved competencies of the PHCC staff (output B): The effect of training on knowledge and skills is likely to be durable in the short term but would need regular update in any case. The in-service training plan is not yet anchored within the MoH and backed by adequate human and financial resources. Considering the economic potential of Libya and the presence of international partners all supporting PHC, it can be assumed that sufficient funding can be mobilised if the training package is well known among the international donors and the MoH endorses it.
- Strengthened epidemic preparedness (output C): The project is currently starting a new activity, namely the piloting of event-based surveillance. This is part of the national Integrated Disease Surveillance and Response (IDSR) 'owned' by NCDC. NCDC's roles and responsibilities are sufficiently clear to expect that

the organisation will remain stable (Peters, 2023a; Int_30 partner). The IDSR is also supported by the new bilateral project, 'Health system strengthening and pandemic prevention in Libya' (PN 2021.2077.2) and it could be agreed to hand over the project activities to this other project.

- Improved access to community-based psychosocial-support services (output D): Increased awareness as part of a societal change process is likely to be durable, especially because there is a broad range of actors in this area (Awidat, 2023). Due to the fact that most focal points are already working in the health system and pursue the topic with high ownership (see Effectiveness), it is expected that their capacity and skill will be durable even if their activities may diminish. From the evaluation, there is no clear indication whether access has already improved or not. This depends also on the pending definition of 'community-based psychosocial-support services'; if only PFA is meant it can be assumed that access did indeed improve with the number of trained individuals. If – and this would be technically appropriate (BMZ, 2018) – the entire referral chain starting from the community level is meant, there are still significant gaps in professional mental health care that cannot be solved by the current project.

In summary, results related to outputs A to C still require substantial efforts by the project and its partners to become durable beyond the end of the project, therefore 10 points were deducted. Project achievements towards community-based psychosocial-support services (output D) have still to overcome huge obstacles before institutionalisation, but the project contributed to a momentum that is very likely to be pursued by other national and international actors. Therefore only 2 points were deducted.

Sustainability dimension 3: Durability of results over time – scores **38 out of 50 points**.

Methodology for assessing sustainability

Table 19: Methodology for assessing OECD DAC criterion: sustainability

Sustainability: assessment dimensions	Basis for assessment	Evaluation design and empirical methods	Data quality and limitations
Capacities of the beneficiaries and stakeholders	• Extent to which beneficiaries and stakeholders have the capacity, resources, ownership, and resilience to sustain the results achieved. ('Results' are the current level of achievement of outcome and output indicators) • Can outputs and outcomes can be linked to other partners or new projects have capacities.	**Evaluation design:** No specific evaluation design applied; the analysis follows the evaluation questions from the evaluation matrix **Empirical methods:** • Document analysis • Interviews • FGD, Chat groups • Online surveys.	• Standard project documents and humanitarian needs assessments provide good basis for assessment • Interviews may be positively biased, no full capacity assessment available, but biases were mitigated through triangulation of sources and methods • Good evidence
Contribution to supporting sustainable capacities	Contribution of the project to the capacity, resources, ownership and resilience to sustain the results.	**Evaluation design:** No specific evaluation design applied; the analysis follows the evaluation questions from the evaluation matrix. **Empirical methods:** • Document analysis • Interviews • FGD	• Broad range of project documents to track all activities but only anecdotal evidence on changed behaviours of providers, managers FPs etc., observation on-site was not possible as planned due to openings hours and timing of visits • No written exit strategy but a FGD with project team to explore strategy in depth • Moderate evidence

Sustainability: assessment dimensions	Basis for assessment	Evaluation design and empirical methods	Data quality and limitations
Durability of results over time	Extent to which the results achieved will be durable over time (prognosis)	**Evaluation design:** Prognosis of the durability of results, based on results achieved; the analysis follows the evaluation questions from the evaluation matrix **Empirical methods:** • Document analysis • Interviews • FGD	• Due to the fragile context, forecasts are limited and closely linked to the potential impact • Interviews may be positively as well as negatively biased triangulation of methods and sources • Moderate evidence

4.8 Key results and overall rating

The project was overall successful because it managed to implement capacity development in a fragile setting by balancing direct support to the population with a perspective of strengthening structures for public health service delivery. Its main strength was its capacity to network and foster networks. Its main weakness was the lack of a functioning MEAL system. The project was very successful in terms of Relevance and Coherence because of its strong orientation on operationalising the humanitarian-development nexus, that is in accompanying the disrupted health sector during the transition from humanitarian assistance to health systems development. The process is ongoing and will likely take until the next decade. Within this time frame, the project's impact at the higher development level is likely bigger than its current effectiveness at the outcome level: project achievements can be read as an investment into the future. The orientation to the decentralisation process and the cooperation with the TC decentralisation project were two mutually reinforcing success factors in view of Relevance, Coherence and Impact. The project was moderately successful regarding Effectiveness, Efficiency and Sustainability. On the one hand this is still remarkably good, bearing in mind the challenging environment with remote steering, external factors like the COVID-19 pandemic and a seven-month suspension of project activities, high transaction cost due to the security situation and the very limited partner capacities in the disrupted health sector. Success factors were responsiveness to partner needs, conflict sensitivity and a hard working technically solid, complementary national and international team. On the other hand, the project could have been more successful if it had made more active use of results-based monitoring including milestones and the monitoring of risks and assumptions for decision-making in technical and (partly also) in financial decisions. This would have helped to steer implementation towards results and to limit costs which did not contribute to outcomes. More solid data would also have enabled learning from implementation and more strategic communication including the publication of results to attract potential funders for project approaches after its end.

Table 20: Overall rating of OECD DAC criteria and assessment dimensions

Evaluation criteria	Dimension	Max	Score	Total (max.100)	Rating
Relevance	Alignment with policies and priorities	30	28	**93**	Level 1: highly successful
	Alignment with the needs and capacities of the beneficiaries and stakeholders	30	27		
	Appropriateness of the design*	20	18		
	Adaptability – response to change	20	20		
Coherence	Internal coherence	50	48	**96**	Level 1: highly successful
	External coherence	50	48		
Effectiveness	Achievement of the (intended) objectives	30	23	**75**	Level 3: moderately successful
	Contribution to achievement of objectives	30	18		
	Quality of implementation	20	15		
	Unintended results	20	19		
Impact	Higher-level (intended) development changes/results	30	23	**81**	Level 2: successful
	Contribution to higher-level (intended) development results/changes	40	28		
	Contribution to higher-level (unintended) development results/changes	30	30		
Efficiency	Production efficiency	70	50	**71**	Level 3: moderately successful
	Allocation efficiency	30	21		
Sustainability	Capacities of the beneficiaries and stakeholders	20	15	**76**	Level 3: moderately successful
	Contribution to supporting sustainable capacities	30	23		
	Durability of results over time	50	38		
Mean score and overall rating		100	**82**		**Level 2: successful***

Table 21: Rating and score scales

100-point scale (score)	6-level scale (rating)
92–100	Level 1: highly successful
81–91	Level 2: successful
67–80	Level 3: moderately successful
50–66	Level 4: moderately unsuccessful
30–49	Level 5: unsuccessful
0–29	Level 6: highly unsuccessful
Overall rating: The criteria of effectiveness, impact and sustainability are knock-out criteria: If one of the criteria is rated at level 4 or lower, the overall rating cannot go beyond level 4 although the mean score may be higher.	

5 Conclusions and recommendations

5.1 Key findings and factors of success/failure

- According to the principles of transitional development assistance, the project had to constantly balance the need for direct short-term results at the level of the population and the need to develop structures for a transition out of the humanitarian situation. The key success factors were a skilled and well-connected national project team, flexibility and the willingness to learn and listen, and the ability to adjust the project strategy. The relatively long duration of the project was also an important precondition for these changes. The most limiting factors for the project, which were to some degree linked were a certain lack of priority setting based on a strong results focus and the lack of a functioning MEAL system. While the project still managed to learn and adjust due to its connectedness, it had big difficulties to substantiate decisions with data, to track risks and to adjust strategy according to risks. The gaps in monitoring also limit learning from project evaluation, which makes it more difficult to 'market' project approaches so that sufficient funds for upscaling (impact) and sustainably can be mobilised by or with help of the project. The lack of evidence is also an area of non-alignment with the otherwise well-reflected transitional development assistance strategy of BMZ, which explicitly requires a stronger integration of impact and evaluation approaches.
- After changing its strategy towards a stronger focus on the development of structures (management and in-service training capacities), the risk for achieving the direct results (project objective indicators) increased considerably, at the same time its impact, that is the indirect contribution to higher development goals increased. However – and this is not untypical for higher development goals – the benefit of project interventions in terms of those goals can only be harvested in the mid to long term and only if the positive achievements can be durable and further developed. The project didn't have an explicit exit strategy and it did not identify and monitor the risks related to impact; it also didn't have a communication strategy to share and advocate for those approaches that it considered being meaningful beyond the direct partners of the project.

- The project was fully embedded in a comprehensive approach of German cooperation to strengthen the municipalities. This led to short-term synergies (e.g. the rehabilitation of PHCCs, a more effective COVID-19 response) and is likely instrumental in view of achieving impact. Unfortunately, the interventions so far are not based on a detailed capacity assessment in terms of capacities for effective decentralisation of PHC provision. For example, there are no linkages between the project and the support to local development planning provided by the Decentralisation project. It was difficult for the evaluators to assess the concrete progress in terms of municipal strengthening through the project and it will be difficult for the project to clearly communicate its approaches and to get buy-in for a good handover (to partners or to the Decentralisation project). Since several GIZ health projects work on the decentralisation process, learning from the project may be of high relevance to other projects.
- The project results clearly underline that the infrastructure, consumables, medicines, and human capacity building are inseparable. The lack of any of these components poses a high risk for Effectiveness and Impact and may jeopardise Efficiency.

Findings regarding Agenda 2030

Universality, shared responsibility and accountability

The project made a plausible contribution to the SDGs (Impact), most directly to UHC as the centrepiece of SDG 3 (health). Better public service provision in the health sector through improved PHC provision (project objective) increases trust in the state and thereby contributes to SDG 16 (peace, stability, and strong institutions). The project helped to strengthen the partners' PHCCs by empowering municipalities to understand and implement national strategies, namely the Family Practice Approach and national COVID-10 response plan. The intervention sites were selected in close cooperation with national and international partners (Coherence) respecting a division of work between the different supporting agencies. There were no indications of duplication. There were no shared systems for monitoring, learning and accountability beyond the health cluster meetings and technical working groups. The project contributed to these as long as they were functioning. Since 2023, the health cluster has stopped operations and the MoH has not yet set up a cooperation structure for the health sector. The project has also supported the roll-out of the national health information system (DHIS2), which may eventually become a basis for joint monitoring, learning and accountability in the health sectors. With a series of management workshops, the project provides a platform for learning in the health sector.

Interplay of economic, environmental and social development

The project focuses on the social dimension of sustainable development by improving health service provisions and participation. However, access to PHC has an important economic dimension because people have to pay diagnostics and treatments that are not provided in the public sector if they need health care. Out-of-pocket expenditure can lead to catastrophic health expenditure. Lack of prevention and early detection at the primary level often increase the risk for catastrophic expenditure. The project has also facilitated access to the Study and Expert Fund and overseen the implementation of Study and Expert Fund interventions that directly address the environment like waste management. These are important initiatives to avoid for unintended negative effects of increased access to health care but were not part of the evaluation.

Inclusiveness/leave no one behind

The project acknowledged the rights of people with disabilities and other disadvantaged groups as a key principle and actively conducted trainings and workshops with representatives of vulnerable groups to operationalise the LNOB principle. However, in a situation where health facilities were barely functioning, the project had difficulties to identify and implement specific interventions for specific subgroups of the communities. It is an important lesson learnt of the project that local definitions of 'disadvantaged' and

‘vulnerable’ have to be developed before designing interventions, and it is necessary to negotiate consensus around these.

5.2 Recommendations

GIZ project team

- The evaluators saw limited scope for identifying and meeting specific needs of disadvantaged population groups including migrants. It is recommended to use the remaining time of the project to identify and negotiate common definitions of who is disadvantaged and what the most promising activities are. In view of obtaining viable results, it is not recommended to embark on detailed activities but to identify and mobilise suitable promising partners including, but not limited to the Norwegian Refugee Council (FC, Ajdabiya), Care (sexual and reproductive rights), ‘Socio-economic participation of vulnerable groups in Libyan municipalities’ (TC Cooperation, Zintan and Jakharra).
- The evaluation clearly highlighted the negative effect of the lack of a functioning MEAL system for the success in all criteria. The evaluation also highlighted the difficulties in setting priorities. Therefore, it is recommended to invigorate the MEAL system but with a clear focus on monitoring risks for impact and constantly finetuning implementation and communication towards the mitigation of those risks. In addition, it is recommended to sharpen and focus result-monitoring on those interventions that will need handing over to national and international partners (e.g. the results of the management-meetings and not so much the satisfaction of patients per se). The evaluation also highlighted that the agreed indicators have partly limited relevance. Therefore, the project should not use scarce resources to track indicators that only serve reporting.
- The evaluation showed that MHPSS interventions of the project have very successfully led to awareness and that there is an active network of MHPSS FPs. The project is building PHCCs’ capacity to provide basic mental health services and linking this to community-based MHPSS interventions and referral to tertiary/specialist care, which is available in the more populated coastal cities. However, it also showed that the referral system is still largely insufficient. In line with good practice and BMZ recommendations, it is strongly recommended to focus on effective referral of those who are in need.
- The evaluation indicates that the direct support to PHCCs has very limited sustainability. It is recommended to further analyse and document this important lesson learnt.
- The evaluation has shown that multiple risks for sustainability exist. It is therefore recommended to focus all efforts on a sound exit strategy. This should cover the reinforcement of existing networks, capacity building at the municipal level and the adequate consideration of the health sector in the roadmap, the mobilisation of resources, e.g. for implementation of the in-service PHC training plan and the effective communication of lessons learnt to support policymaking in favour of effective and efficient PHC.

GIZ Libya cluster

- The project found that synergies with the health cluster were used very well but could still be further increased, especially in view of impact and sustainability of the project. It is recommended to actively facilitate and support a project exit strategy involving all projects within the cluster.

GIZ in general/GIZ headquarters

- The evaluation indicates that the project design did not translate the transitional development assistance in view of the integration of impact and evaluation approaches in the design and daily practice. It is recommended to review already existing good practice, to consider this aspect in further internal quality assurance processes and to reflect how projects could be supported in using impact-related data more tangibly in design and implementation practice. Third party monitoring and operational research could be two important features of projects in fragile contexts to increase objectivity and to provide more opportunity to learn from implementation.

- The evaluation indicates that the COVID-19 measures that were not fully integrated in the project design and did not contribute to the achievement of objectives had a negative effect on the project's efficiency (and probably on its overall capacity to focus on its key results). The COVID-19 measures were not in the agreed focus of the evaluation, so there is limited data. However, the international evaluator has made similar observations in other projects. It is recommended to propose an overarching assessment of the impact of COVID-19-related procurements on the success and quality of projects implemented during the pandemic and to assess whether in future health crises the same approach should be repeated or not.

KfW

- The evaluation pointed to potential synergies in view of promoting the right to health care for migrants. It is recommended to facilitate a concretisation of potential synergies between the project implemented with the Norwegian Refugee Council and the TC project especially in view of impact of both measures and the sustainability of the TC project.

MoH

- The evaluation showed that there is a considerable risk that the in-service training plan will not be rolled out successfully if there is insufficient adherence and support from MoH and/or international partner, insufficient follow-up, and insufficient equipment/commodities to allow trainees to apply what they have learnt. It is recommended to strategically communicate the plan, advocate for joint implementation, and mobilise sufficient resources.
- The evaluation highlighted the crucial importance of strategic fund allocation for PHC based on agreed service packages. It is recommended to rapidly advance policies to support finalisation and implementation of the essential service package.
- The evaluation showed that there is a limited understanding of equity issues among health care providers and managers at the municipal level. It is recommended to further operationalise the national law of equal access to free services through supportive policies and strategic fund allocation to the primary level.

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Annex: Evaluation matrix

OECD DAC criterion Relevance: Is the intervention doing the right things? (max. 100 points)
The 'relevance' criterion focuses on the intervention's design. It refers to the extent to which the objectives and design of a development intervention are consistent with the (global, country and institution-specific) requirements, needs, priorities and policies of beneficiaries and stakeholders (individuals, groups, organisations and development partners). It also identifies the ability of the intervention's design to adapt to a change in circumstances. 'Relevance' is assessed in relation to 1) the time of the intervention design[1] and 2) from today's perspective[2]

Assessment dimensions	**Filter - project type**	**Evaluation questions**	**Clarifications**	**Basis for assessment/ evaluation indicators** *(e.g. module objective/programme indicators, selected hypotheses, or more generally a definition of the aspects to be used for evaluation)*	**Evaluation design and empirical methods** (Design: e.g. contribution analysis, follow-the-money approach) (Methods: e.g. interviews, FGD, document analysis, project/partner monitoring system, workshop, online survey, etc.)	**Data sources** (e.g. list of relevant documents, interviews with stakeholder category XY, specific data, specific monitoring data, specific workshop(s), etc.)	**Data quality and limitations** (Description of limitations, assessment of data quality: poor, moderate, good, strong)	**Data quality assessment** (weak, moderate, good, strong)
Alignment with policies and priorities	Standard	To what extent are the intervention's objectives aligned with the (global, regional and country specific) policies and priorities of the BMZ and of the beneficiaries and stakeholders and other (development) partners? To what extent do they take account of the relevant political and institutional environment?	• Orientation at BMZ country strategies and BMZ sector concepts • Strategic reference framework for the project (e.g. national strategies including the national implementation strategy for Agenda 2030, regional and international strategies, sectoral and cross-sectoral change strategies, in bilateral projects especially partner strategies, internal analytical framework e.g. safeguards and gender)[4] • Orientation of the project design at the (national) objectives of Agenda 2030 • Project contribution to certain Sustainable Development Goals (SDGs) • Explanation of a hierarchy of the different policies, priorities (especially in case of contradictions)	Extend of alignment with •BMZ Strategy on Transitional Development Assistance •The European Council Conclusions on operationalising the Humanitarian-Development Nexus •Compliance with iPCA.	**Evaluation design:** No specific evaluation design applied; the analysis follows the evaluation questions from the evaluation matrix. **Empirical methods:** • document analysis • Interviews	**Document analysis:** Project proposal and modification proposals, iPCA, BMZ's transitional development assistance strategy, European Council Conclusions on operationalising the humanitarian-development nexus, Study on Human resource development in fragile settings, **Interviews**: Partners, GIZ	• Proposal and iPCA provide a solid sectoral background and context description of the project, • Partner priorities were specified through interviews	good

	and Fragility	To what extent was the (conflict) context of the project adequately analysed and considered for the project concept?	• Key documents: (Integrated) Peace and Conflict Assessment (I)PCA, Safeguard Conflict and Context Sensitivity documents						
Alignment with the needs and capacities of the beneficiaries and stakeholders	Standard	To what extent are the intervention's objectives aligned with the development needs and capacities of the beneficiaries and stakeholders involved (individuals, groups and organisations)?	• Key documents: (Integrated) Peace and Conflict Assessment (I)PCA, Safeguard Conflict and Context Sensitivity documents	Alignment with the needs and capacities of • health care providers • health care managers • municipalities • alignment with the health needs of the population in the intervention sites • identification of connectors, dividers, security risks and their consideration.	**Evaluation design:** The analysis follows the evaluation questions from the evaluation matrix; triangulation of methods and sources (see below). **Empirical methods:** • Document analysis • Interviews • Chat & FGD • Survey • Inception workshop	**Document Analysis:** Project proposal and modification proposals, project progress reports, KOMPASS, cross-sectoral assessment capacity development in fragile settings, needs assessment by the project (Proximity International/IMC), multisector needs assessments, specifically health (REACH). Gender analysis **Interviews:** Clients of health centres, partners, donor, civil society and private sector **Chat:** Key informants vulnerable peoples, MHPSS focal points. **FGD:** GIZ **Surveys**: District Health Managers; PHCC Managers	• Project standard documents provided a sound basis to compare project approach with needs • triangulation with humanitarian needs assessments and key informants • risk monitoring for entire Cluster, project specific risk monitoring not updated since 2021.	good
	and Fragility	How were deescalating factors/ connectors[5]/peace and human rights needs as well as escalating factors/ dividers[6] in the project context identified and considered for the project concept (please list the factors)? [7]	• Key documents: (Integrated) Peace and Conflict Assessment (I)PCA, Safeguard Conflict and Context Sensitivity documents						
	and Fragility	To what extent were potential (security) risks for (GIZ) staff, partners, target groups/final beneficiaries identified and considered?							
	Standard	To what extent are the intervention's objectives geared to the needs and capacities of particularly disadvantaged and vulnerable beneficiaries and stakeholders (individuals, groups and organisations)? With respect to groups, a differentiation can be made by age, income, gender, ethnicity, etc.?	• Reaching particularly disadvantaged groups (in terms of Leave No One Behind, LNOB) • Consideration of potential for human rights and gender aspects • Consideration of identified risks						
Appropriateness of the design[3]	Standard	To what extent is the intervention's design appropriate and realistic (in terms of	• Realistic project goal from today's perspective and in view of the available resources	Extent to which the methodological approach proposals are a realistic and	**Evaluation design:** • Theory-based evaluation	**Document analysis:** Project proposal and modification proposals, results model, results	•Project standard documents sufficient for assessment, •ToC and changes in the approach have been	good	

			technical, organisational and financial aspects)?	(time, finances, partner capacities) • Consideration of potential changes in the framework conditions • Dealing with the complexity of framework conditions and strategic reference frameworks and with possible overloading • Strategic focusing	plausible pathway towards reaching the intended results: •Does the ToC detail how the project activities are expected to deliver the expected results? •Who are the projects boundary partners and how likely are they to respond to the provided support? How do they influence other stakeholders and what was the envisaged ripple effect? •Have potential internal/external influences/risks been factored into the design?	**Empirical methods:** • Document review • Detailed discussion of the project ToC during the inception workshop with partners and project team.	matrix, capacity development strategy, family practise approach (WHO EMRO),SARA (ter Veen). **Interviews**: GIZ, partners	discussed extensively in inception workshop.		
		Standard	To what extent is the intervention's design sufficiently precise and plausible (in terms of the verifiability und traceability of the system of objectives and the underlying assumptions)?	Assessment of the (current) results model and results hypotheses (theory of change, ToC) of the actual project logic: • Adequacy of activities, instruments and outputs in relation to the project objective to be achieved • Plausibility of the underlying results hypotheses • Clear definition and plausibility of the selected system boundary (sphere of responsibility) • Appropriate consideration of potential influences of other donors/ organisations outside the project's sphere of responsibility • completeness and plausibility of assumptions and risks for the project results • How well is co-financing (if any) integrated into the overall concept of the project and what added value could be generated for the ToC/project design?						
		Standard	To what extent is the intervention's design based on a holistic approach to sustainable development (interaction of the social, environmental and economic	• Presentation of the interactions (synergies/trade-offs) of the intervention with other sectors in the project design - also with regard to the sustainability dimensions in terms of Agenda 2030						

		dimensions of sustainability)?	(economic, ecological and social development)					
Adaptability – response to change	Standard	To what extent has the intervention responded to changes in the environment over time (risks and potentials)?	• Reaction to changes during project including change offers (e.g. local, national, international, sectoral changes, including state-of-the-art sectoral know-how)	Extent to which the project identified significant changes in the context and how the project responded to these changes based on the four official change offers (May 2020, Sept 2020, Nov 2021, Nov 2022).	**Evaluation design:** Context and project mapping) **Empirical methods:** • Document analysis, • Interviews, • FGDs.	**Document analysis:** Proposal and modification proposals, operational plans, progress reports Interviews: GIZ, donor **FGD:** GIZ.	Project progress reports, operational plans and modification offers give substantiated information on the context changes. These can be triangulated with stakeholder interviews.	strong

(1) The 'time of the intervention design' is the point in time when the offer/most recent modification offer was approved.
(2) (2) In relation to the current standards, knowledge and framework conditions.
(3) The design of an intervention is usually assessed by evaluating its intervention logic. The intervention logic depicts the system of objectives used by an intervention. It maps out the systematic relationships between the individual results levels. At the time an intervention is designed, the intervention logic, in the form of a logical model, is described in the offer for the intervention both as a narrative and generally also on the basis of a results framework. The model is reviewed at the start of an evaluation and adjusted to reflect current knowledge. Comprehensive (re)constructed intervention logics are also known as 'theories of change'. In GIZ the 'project design' encompasses project objective (outcome) and the respective ToC with outputs, activities, TC instruments and especially the results hypotheses as well as the implementation strategy (e.g. methodological approach, Capacity Development strategy). In GIZ the ToC is described by the GIZ results model as graphic illustration and the narrative results hypotheses.
(4) In the GIZ Safeguards and Gender system risks are assessed before project start regarding following aspects: gender, conflict, human rights, environment and climate. For the topics gender and human rights not only risks but also potentials are assessed. Before introducing the new safeguard system in 2016 GIZ used to examine these aspects in separate checks.

(5) Deescalating factors/connectors/peace needs: e.g. peace-promoting actors and institutions, structural changes, peace-promoting norms and behaviour. For more details on 'connectors' see: GIZ (2007): Peace and Conflict Assessment (PCA). Ein methodischer Rahmen zur konflikt- und friedensbezogenen Ausrichtung von EZ-Maßnahmen', p. 55/135 and the iPCA Writing Template.

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

(7) All projects in fragile contexts, projects with FS1 or FS2 markers and all transitional development assistance projects should weaken escalating factors/dividers and have to mitigate risks in the context of conflict, fragility and violence (and human rights). Projects with FS1 or FS2 markers should also consider how to strengthen deescalating factors/ connectors and how to address peace needs in its project objective/sub-objective.

OECD DAC criterion Coherence: How well does the intervention fit? (max. 100 points)
This criterion refers to the intervention's compatibility with other interventions in a country, sector or institution as well as with international norms and standards. **Internal coherence** addresses the synergies and division of tasks between the intervention and other interventions of German development cooperation and also the intervention's consistency with the relevant international norms and standards to which German development cooperation adheres. **External coherence** considers the intervention's complementarity, harmonisation and coordination with the interventions of other partners, donors and international organisations. The 'coherence' criterion relates both to the intervention's design as well as to the results it achieves.

Assessment dimensions	**Filter - project type**	**Evaluation questions**	**Clarifications**	**Basis for assessment/ evaluation indicators** *(e.g. module objective/programme indicators, selected hypotheses, or more generally a definition of the aspects to be used for evaluation)*	**Evaluation design and empirical methods** (Design: e.g. contribution analysis, follow-the-money approach) (Methods: e.g. interviews, FGD, document analysis, project/partner monitoring system, workshop, online survey, etc.)	**Data sources** (e.g. list of relevant documents, interviews with stakeholder category XY, specific data, specific monitoring data, specific workshop(s), etc.)	**Data quality and limitations** (Description of limitations, assessment of data quality: poor, moderate, good, strong)	**Data quality assessment** (weak, moderate, good, strong)
Internal coherence	Standard	Within German development cooperation, to what extent is the intervention designed and implemented (in a sector, country, region or globally) in a complementary manner, based on the division of tasks?	• Also analysis of whether the project takes the necessary steps to fully realise synergies within German development cooperation	The extent to which the project has harnessed synergies for greater outcomes and efficiency gains within the GIZ Libya cluster and between Financial and Technical Cooperation	**Evaluation design:** Analysis follows the evaluation questions from the evaluation matrix. **Empirical methods:** • Document review, • Interviews, • FGD.	**Document analysis:** Overview of the GIZ Libya, Report of the German Embassy Tripoli, Portfolio, Project proposals and proposals of decentralisation project. health systems strengthening project and the project Socio-economic participation of vulnerable groups in Libyan municipalities, project progress reports. do-augmentation of the Humanitarian World Summit. The Do-No Harm Handbook. **Interviews:** GIZ, donors FGD: GIZ	• Good documentation for all projects in the Libya Cluster plus the report of the German Embassy provide a strong data base. The documents were triangulated with a range of interviews.	strong
	Standard	To what extent are the instruments of German development cooperation (TC and FC) meaningfully interlinked within the intervention (in terms of both design and implementation)? Are synergies leveraged?	• if applicable, also take into account projects of different German resorts/ ministries					
	Standard	To what extent is the intervention consistent with international and national norms and standards to which German development cooperation is committed (e.g. human rights)?						
External coherence	Standard	To what extent does the intervention complement and support the partner's own efforts (principle of subsidiarity)?		The extent to which the project balanced immediate support for the population and the need to strengthen partner structures, coordinates with and complements	**Evaluation design:** Analysis follows the evaluation questions from the evaluation matrix. **Empirical methods:** Document analysis, Interviews, FGDs	**Document analysis:** project proposals and progress reports, Capacity Development in Fragile Settings (Brinkerhoff, GIZ, SARA, IMC final report, concept note for the management workshop	• Assessment relies mainly on the project's own reports which were triangulated with a limited number of key informants (donors, GIZ and MoH),	moderate

	Standard	To what extent has the intervention's design and implementation been coordinated with other donors' activities?	• Also: To what extent could synergies be achieved through co-financing (where available) with other bilateral and multilateral donors and organisations and how did co-financing contribute to improved donor coordination?	interventions by other development actors, realises synergies, and the extent to which the project gears own MEAL efforts to strengthen systems and structures of the partners.		series, Analysis of DHIS2 Operational Status in Libya) (Giha) **Interviews:** partners, civil society and private sector, GIZ **FGD:** GIZ.		
	Standard	To what extent has the intervention's design been designed to use existing systems and structures (of partners/other donors/international organisations) for implementing its activities? To what extent are these systems and structures used?	• Also analysis of whether the project is taking the necessary steps to fully realise synergies with interventions of other donors at the impact level					
	Standard	To what extent are common systems (together with partners/other donors/international organisations) used for monitoring, evaluation, learning and accountability?						

OECD DAC criterion Effectiveness: Is the intervention achieving its objectives? (max. 100 points)
'Effectiveness' refers to the extent to which the intervention has achieved, or is expected to achieve, its objectives (at outcome level), including any differential results across beneficiary and stakeholder groups. It examines the achievement of objectives in terms of the direct, short-term and medium-term results.

Assessment dimensions	**Filter - project type**	**Evaluation questions**	**Clarifications**	**Basis for assessment / evaluation indicators** *(e.g. module objective/programme indicators, selected hypotheses, or more generally a definition of the aspects to be used for evaluation)*	**Evaluation design and empirical methods** (Design: e.g. contribution analysis, follow-the-money approach) (Methods: e.g. interviews, FGD, document analysis, project/partner monitoring system, workshop, online survey, etc.)	**Data sources** (e.g. list of relevant documents, interviews with stakeholder category XY, specific data, specific monitoring data, specific workshop(s), etc.)	**Data Quality and limitations** (Description of limitations, assessment of data quality: poor, moderate, good, strong)	**Data Quality Assessment** (weak, moderate, good, strong)
Achievement of the (intended) objectives[1]	Standard	To what extent has the intervention achieved, or is the intervention expected to achieve, the (intended) objectives as originally planned (or as modified to cater for changes in the environment)?	• Assessment based on the project objective indicators (agreed with BMZ) • Check whether more specific or additional indicators are needed to adequately reflect the project objective	Extent to which the project objective was achieved (based on the achievement of the objective indicators) (see Table 11) with a critical consideration of the specificity and relevance of these indicators, • Extent to which the project was able to strengthen connectors/weaken dividers.	Evaluation design: Analysis follows the evaluation questions from the evaluation matrix. Empirical methods: • Document and secondary data analysis • Interviews • FGD and Chat Groups • Online surveys	**Document analysis:** •Patient satisfaction data from IMC, data from IMC/project on output indicators via email, Grant (IMC) and consultant reports (GFA: NCD training), IMC reports on a) Assessment on accessibility of COVID-19 services and b: training on PFA, project progress reports and updated results matrix I**nterviews:** GIZ, civil society and private sector, clients of health centres, partners **FGDs:** GIZ **Online surveys:** PHCC managers, District Health managers, **Chat:** key informants for vulnerable groups, MHPSS FPs.	• Limited monitoring data • secondary data scarce, • method and stakeholder triangulation possible, • high number of key informants; however only anecdotal evidence.	Moderate
	and Fragility	For projects with FS1 or FS2 markers: To what extent was the project able to strengthen deescalating factors/ connectors/ capacities of peace?[2, 4]						
Contribution to achievement of objectives	Standard	*To what extent have the intervention's outputs been delivered as originally planned (or as modified to cater for changes in the environment)?*		The extent to which it is plausible that the project's activities and outputs contributed to/will contribute to the achievement of outcome results, looking at the	**Evaluation design:** Contribution analysis: This design consists of a 'specific analysis undertaken to provide information on the contribution of a program to the	**Document analysis:** IMC Data on functionality, Consultant report (GFA): NCD training, project progress reports, concept note management workshop series, PCI progress reports, IMC	• Hypothesis 1: Triangulation of implementer reports with interviews, • Hypothesis 2: information on workshops but very limited evidence on management practice, • Hypothesis 3: Activity is not yet	moderate

	Standard	To what extent have the delivered outputs and increased capacities been used and equal access (e.g. in terms of physical, non-discriminatory and affordable access) guaranteed?		results hypotheses) see Table 11).	outcomes' (Mayne, 199, p.6). It is chosen to understand how and why PHC provision in Libya has been improved by the project. **Empirical methods:** • Document analysis • Interviews • Online survey • FGDs and Chat groups • Inception workshop • Debriefing workshop.	report on training on PFA, MHPSS KAP study, overview of MHPSS activities in Libya (Awidat) **Interviews** with all stakeholders (see list of involved stakeholders in the inception report) **Online surveys:** PHCC managers, District Health managers, **FGDs** GIZ **Inception workshop**: Discussion of focus of evaluation with partners and project team **Debriefing workshop: p**resentation and discussion of preliminary findings.	fully implemented, evidence on output and indication on use of output, not on outcome, • Hypothesis 4: good triangulation of reports, Chat Groups and interviews,	
	Standard	To what extent has the intervention contributed to the achievement of objectives?	• Assessment based on the activities, TC instruments and outputs of the project (contribution analysis as focus of this assessment dimension and minimum standard, see annotated reports) • What would have happened without the project? (Usually qualitative reflection)					
	Standard	To what extent has the intervention contributed to the achievement of objectives at the level of the intended beneficiaries?						
	Standard	To what extent has the intervention contributed to the achievement of objectives at the level of particularly disadvantaged or vulnerable groups of beneficiaries and stakeholders? (These may be broken down by age, income, gender, ethnicity, etc.)?						
	Standard	*Which internal factors (technical, organisational or financial) were decisive for achievement/non-achievement of the intervention's intended objectives?*	• Internal factors = within the project's sphere of responsibility / system boundary. The project is implemented jointly by GIZ and the official partner(s).					
	Standard	*Which external factors were decisive for achievement/non-achievement of the intervention's intended objectives (taking into account the anticipated risks)?*	• External factors = outside the project's sphere of responsibility / system boundary. The project is implemented jointly by GIZ and the official partner(s).					

Quality of implementation	Standard	What assessment can be made of the quality of steering and implementation of the intervention in terms of the achievement of objectives? What assessment can be made of the quality of steering and implementation of, and participation in, the intervention by the partner/executing agency?	Capacity WORKS considerations: - **Results-oriented monitoring (RoM / WoM)** is established and used, e.g. for evidence-based decisions, risk management. Data are disaggregated by gender and marginalised groups. unintended positive and negative results are monitored. Conflict-sensitive monitoring and explicit risk-safety monitoring are particularly important for projects in fragile contexts. - A bindingly communicated **strategy** agreed with the partners is pursued - Involvement and **cooperation** of all relevant actors (including partners, civil society, private sector) - **Steering**: decisions influencing the projects' results are made in time and evidence-informed. Decision processes are transparent. - **Processes**: Relevant change processes are anchored in the cooperation system; project-internal processes are established and regularly reflected and optimised. - **Learning and innovation**: There is a learning and innovation-friendly work culture that promotes the exchange of experience; learning processes are established; context-specific adjustments are possible	The extent to which the quality of implementation contributed to the success of the project.	**Evaluation design:** Analysis follows the evaluation questions from the evaluation matrix. **Empirical methods:** • Document analysis • Interviews • FGDs • Inception workshop	**Document analysis:** Steering structure overview, reports quarterly technical meetings, operational plans, capacity development strategy, RBM system, KOMPASS, project progress reports. **Interviews:** partner, GIZ, civil society and private sector, donor **FGD:** GIZ **Inception workshop:** Discussion with partners and project team	• Risk of self-serving answers was managed through triangulation of perspectives and methods.	Good

Unintended results	Standard	To what extent can unintended positive/negative direct results (social, economic, environmental and among vulnerable beneficiary groups) be observed/anticipated?	• The focus is on the outcome level, but for the analysis the unintended effects can also be included on the output level	Extent to which • unintended results at output and outcome level have been observed and how the project responded to them. • the project applied conflict-sensitive project management and monitoring at the outcome level.	**Evaluation design:** Verifying assumptions of unintended results in an iterative manner and outcome harvesting **Empirical methods:** • Document analysis • Interviews • FGDs • Inception workshop.	**Document review** Gender analyses, iPCA, project. KOMPASS, capacity development strategy, concept note management workshop series, **Interviews** with all stakeholders **FGD:** GIZ **Inception workshop:** Brainstorming on unintended effects with partners and project team	• Anticipated unintended results from Gender analysis, iPCA and inception interviews discussed, unintended effects explored during interviews and FGD.	good
	and Fragility	To what extent was the project able to ensure that escalating factors/ dividers[3] have not been strengthened (indirectly) by the project[4]? Has the project unintentionally (indirectly) supported violent or 'destructive' actors (also in regard to human rights violations)?						
	Standard	What potential benefits/risks arise from the positive/negative unintended results? What assessment can be made of them?	• also check whether the risks were already mentioned and monitored in the design phase					
	and Fragility	To what extent have risks and unintended negative results in the context of conflict, fragility and violence[5] been monitored (context and/or conflict-sensitive monitoring) in a systematic way?						
	Standard	How has the intervention responded to the potential benefits/risks of the positive/negative unintended results?	• Check if positive results at the outcome level have been monitored and set in value					

(1) The first and second assessment dimensions are interrelated: If the project's contribution to achieving the objective is small (2nd assessment dimension), this must also be taken into account when evaluating the first assessment dimension.

(2) Deescalating factors/ connectors/ peace needs: e.g. peace-promoting actors and institutions, structural changes, peace-promoting norms and behaviour. For more details on 'connectors' see: GIZ (2007): 'Peace and Conflict Assessment (PCA). Ein methodischer Rahmen zur konflikt- und friedensbezogenen Ausrichtung von EZ-Maßnahmen', p. 55/135 and the iPCA Writing Template.

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

(4) All projects in fragile contexts, projects with FS1 or FS2 markers and all transitional development assistance projects should weaken escalating factors/dividers and have to mitigate risks in the context of conflict, fragility and violence (and human rights). Projects with FS1 or FS2 markers should also consider how to strengthen deescalating factors/ connectors and how to address peace needs in its project objective/sub-objective.

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

OECD DAC criterion Impact (higher-level development results): What difference does the intervention make? (max. 100 points)
Based on recognisable higher-level development changes (at impact level), the criterion of 'higher-level development results (at impact level)' relates to the extent to which the intervention has already produced significant positive or negative, intended or unintended results at the overarching level (contributions to the observed changes) or is expected to do so in the future. This includes any differential results across different stakeholders and beneficiaries. This criterion refers to the results of the development intervention.

Assessment dimensions	**Filter - project type**	**Evaluation questions**	**Clarifications**	**Basis for assessment / evaluation indicators** *(e.g. module objective/programme indicators, selected hypotheses, or more generally a definition of the aspects to be used for evaluation)*	**Evaluation design and empirical methods** (Design: e.g. Contribution analysis, Follow-the-Money Approach) (Methods: e.g. interviews, FGD, document analysis, project/partner monitoring system, workshop, online survey, etc.)	**Data sources** (e.g. list of relevant documents, interviews with stakeholder category XY, specific data, specific monitoring data, specific workshop(s), etc.)	**Data quality and limitations** (Description of limitations, assessment of data quality: poor, moderate, good, strong)	**Data quality assessment** (weak, moderate, good, strong)
Higher-level (intended) development changes[1]	Standard	To what extent can the higher-level development changes (social, economic and environmental dimensions and the interactions between them) to which the intervention will/is designed to contribute be identified/foreseen)? (Specify time frame where possible.)	'• Consider module proposal for suggested impact and programme objective indicators (programme proposal), if it is not an individual measure • Potential basis for assessment: programme objective indicators, identifiers, connection to the national strategy for implementing 2030 Agenda, connection to SDGs	Extent to which project-related higher-level changes could be observed or foreseen in terms of SDGs and policy markers for gender equity, Governance, poverty and peace, LNOB and trade-offs between concrete support with a direct effect for the population and structural support.	**Evaluation design**: No specific evaluation design applied; the analysis follows the evaluation questions from the evaluation matrix. **Empirical methods:** • Document analysis, • Secondary data analysis, • Interviews.	**Document analysis:** WHO assessment of progress towards SDGs, report of the German Embassy Tripoli, roadmap towards empowering communities, project proposals, costing of the essential health service package, progress reports, humanitarian multisector needs assessments **Interviews:** Civil society and private sector, donor, partner	• No statistical data or forecasts on UHC and gender equity, • only indicative data triangulated with limited expert views, • political development and speed of peace process cannot be assessed.	weak
	Standard	To what extent can the higher-level development changes (social, economic, environmental dimensions and the interactions between them) be identified/foreseen at the level of the intended beneficiaries? (Specify time frame where possible.)						
	Standard	To what extent can higher-level development changes to which the intervention will/is designed to contribute be identified/foreseen at the level of particularly disadvantaged/vulnerable groups of beneficiaries and stakeholders? (These may be broken down by age, income, gender, ethnicity, etc.)						

		(Specify time frame where possible.)						
Contribution to higher-level (intended) development changes	Standard	To what extent has the intervention actually contributed to the identified and/or foreseeable higher-level development changes (social, economic, environmental dimensions and their interactions, taking into account political stability) that it was designed to bring about?	• Contribution analysis (evaluation design) as minimum standard and focus of this assessment dimension, further approaches are possible and welcome, see also annotated reports • Evaluation of the project's contribution to impacts based on an analysis of the results hypotheses from outcome to impact level,	Extent to which the contribution of the project to higher development changes can be identified based on two selected results hypotheses from project objective to impact level as specified in Table 14.	**Evaluation design:** Contribution analysis **Empirical methods:** • Document analysis, • Interviews, • FGDs, • Chat • Inception workshop.	**Document analysis:** WHO website on PHC, project progress reports, German Embassy report, multisector needs assessment, costing of the essential health service package. **Interviews:** GIZ, Civil society and private sector. partners **FGDs**: GIZ **Chat:** Key informants for vulnerable groups **Inception workshop:** Discussion of results model with project team and partners.	• Assumptions in the impact logic can only be substantiated anecdotal evidence, • views and interpretations are subjective; this was partly mitigated through a triangulation of sources and methods.	moderate
	Standard	To what extent has the intervention achieved its intended (original and, where applicable, revised) development objectives?	• This question can already be assessed in dimension 1 Question 1, the contribution to impact is assessed in dimension 2, Question 1.					
	Standard	To what extent has the intervention achieved its (original and, where applicable, revised) development objectives at the level of the intended beneficiaries?						
	Standard	To what extent has the intervention contributed to higher-level development changes/changes in the lives of particularly disadvantaged or vulnerable groups of beneficiaries and stakeholders that it was designed to bring about? (These may be broken down by age, income, gender, ethnicity, etc.).						
	Standard	Which internal factors (technical, organisational or financial) were decisive for achievement/non-achievement of the intervention's intended development objectives?	• Internal factors = within the project's sphere of responsibility / system boundary. The project is implemented jointly by GIZ and the official partner(s)					

		Standard	Which external factors were decisive for the achievement/non-achievement of the intervention's intended development objectives?	• External factors = outside the project's sphere of responsibility / system boundary. The project is implemented jointly by GIZ and the official partner(s). • Take into account the activities of other actors or other policies, framework conditions, other policy areas, strategies or interests (German ministries, bilateral and multilateral development partners)					
		Standard	To what extent has the intervention achieved structural or institutional changes (e.g. for organisations, systems and regulations)?						
		Standard	To what extent did the intervention serve as a model and/or achieve broad-based impact?	• Scaling-up is a consciously designed process to anchor changes in organisations and cooperation systems (e.g. concepts, approaches, methods) to generate broad impact • There is vertical scaling-up, horizontal scaling-up, functional scaling-up or a combination of [2] • also analyse possible potential and reasons for not exploiting it					
		Standard	How would the situation have developed without the intervention?	• Usually qualitative reflection, quantitative approaches welcome					
	Contribution to higher-level (unintended) development changes	Standard	To what extent can higher-level, unintended development changes (social, economic, and environmental dimensions and their interactions, taking into account political stability) be identified/foreseen? (Specify time frame where possible.)		Whether • unintended development changes have been observed and the extent to which the project contributed and responded to these, • dividers and connectors have	**Evaluation design:** Outcome harvesting applied at impact level. **Empirical methods:** • Document analysis • Interviews • FGD	**Document analysis:** iPCA, gender analysis, The Long Road to Inclusive Institutions in Libya, Do-no-harm handbook, **Interviews:** GIZ, CSPS	• No information on unintended higher-level changes through interviews and FGD • Assessment only based on document review by evaluators.	weak

		and Fragility	To what extent did the project have (unintended) negative or escalating effects on the conflict, context of fragility or human rights (e.g. conflict dynamics, violence, legitimacy of state and non-state actors/institutions)? To what extent did the project have positive or deescalating effects on the conflict, context of fragility or human rights (e.g. conflict dynamics, violence, legitimacy of state and non-state actors/institutions)?		been identified and weakened / strengthened.					
		Standard	To what extent has the intervention brought about foreseeable/identifiable unintended (positive and/or negative) higher-level development results?	'• Analyse whether the risks were already known in the design phase • Check how the assessment of risks in connection with (unintended) negative or (not formally agreed) positive results at the impact level in the monitoring system has been carried out (e.g. use of 'compass') • measures taken to avoid or counteract the risks/ negative effects/ trade-offs[3] • Determine relevant framework conditions for negative results and the project's reaction to them • Examine to what extent potential (not formally agreed) positive results and synergies between the ecological, economic and social development dimensions have been monitored and exploited						
		Standard	To what extent has the intervention contributed to foreseeable/ identifiable unintended (positive and/or negative) higher-level development results at the level of particularly							

			disadvantaged or vulnerable groups of beneficiaries and stakeholders? (These may be broken down by age, income, gender, ethnicity, etc.)							

(1). The first and second assessment dimensions are interrelated: If the project's contribution to achieving the objective is small (2nd assessment dimension), this must also be taken into account when evaluating the first assessment dimension.
(2) See GIZ 2016 'Guidelines on scaling-up for programme managers (AV) and planning officers'.
(3) Risks, negative effects and trade-offs are separate aspects that should be discussed individually at this point.

OECD DAC criterion Efficiency: How well are resources being used? (max. 100 points)
This criterion describes the extent to which the intervention delivers results in an economic and timely way (relationship between input and output, outcome and impact level). The evaluation dimension '**production efficiency**' refers to the appropriateness of the relationship between inputs and outputs. The evaluation dimension '**allocation efficiency**' refers to the appropriateness of the relationship between the inputs and the results achieved (project/development objective; outcome/impact level) by the intervention. The 'efficiency' criterion relates both to the intervention's design and implementation and to the results it achieves.

Assessment dimensions	**Filter - project type**	**Evaluation questions**	**Clarifications**	**Basis for assessment / evaluation indicators** *(e.g. module objective/programme indicators, selected hypotheses, or more generally a definition of the aspects to be used for evaluation)*	**Evaluation design and empirical methods** (Design: e.g. contribution analysis, follow-the-money approach) (Methods: e.g. interviews, FGD, document analysis, project/partner monitoring system, workshop, online survey, etc.)	**Data sources** (e.g. list of relevant documents, interviews with stakeholder category XY, specific data, specific monitoring data, specific workshop(s), etc.)	**Data quality and limitations** (Description of limitations, assessment of data quality: poor, moderate, good, strong)	**Data quality assessment** (weak, moderate, good, strong)
Production efficiency	Standard	*How are the intervention's inputs (financial, human and material resources) distributed (e.g. by instruments, sectors, sub-interventions, taking into account the cost contributions of partners/executing agencies/other beneficiaries and stakeholders etc.)?*	• Description of the data: Costs per output, type of costs, agreed and provided partner contributions • Description of the deviations between original planned costs and actual costs (with comprehensible justification, changes are certainly desirable for increased efficiency)	Description of the data: Costs per output, type of costs, agreed and provided partner contributions, using GIZ efficiency tool, and the extent to which inputs have been transformed into outputs.	**Evaluation design:** Follow-the-money approach and analytical questions from the evaluation matrix (see Annex). **Empirical methods**: • Document and cost analysis (using GIZ efficiency tool), • Interviews, • Inception discussion.	**Document analysis:** Filled-out template for HR-instruments per output; current project's cost-commitment report during inception and evaluation mission, progress reports incl. results matrix, all sources used to assess effectiveness (see above), Central project evaluation Socio-economic Dialogue in Libya, GFA report on NCD training, PCI progress reports. **Interviews:** GIZ, civil society and private sector- **Inception discussion**	• Retrospective estimation of costs per output, • limited evidence for assessing the achievement of outcome and output indicators, • benchmarking data was barely available (only one recent Evaluation from Libya published with limited financial data), • moderate evidence.	moderate
	Standard	To what extent have the intervention's inputs (financial, human and material resources) been used economically in relation to the outputs delivered (products, investment goods and services)? If possible, refer to data from other evaluations in a region or sector, for instance.	• Use of 'Efficiency tool' including instructions and use of the follow-the-money approach as evaluation design (may be combined with other high-quality approaches) • Output level: Analysis of approaches and activities as well as TC instruments (personnel instruments, financing, materials and equipment)[1] compared to possible alternatives with a focus on the minimum principle					

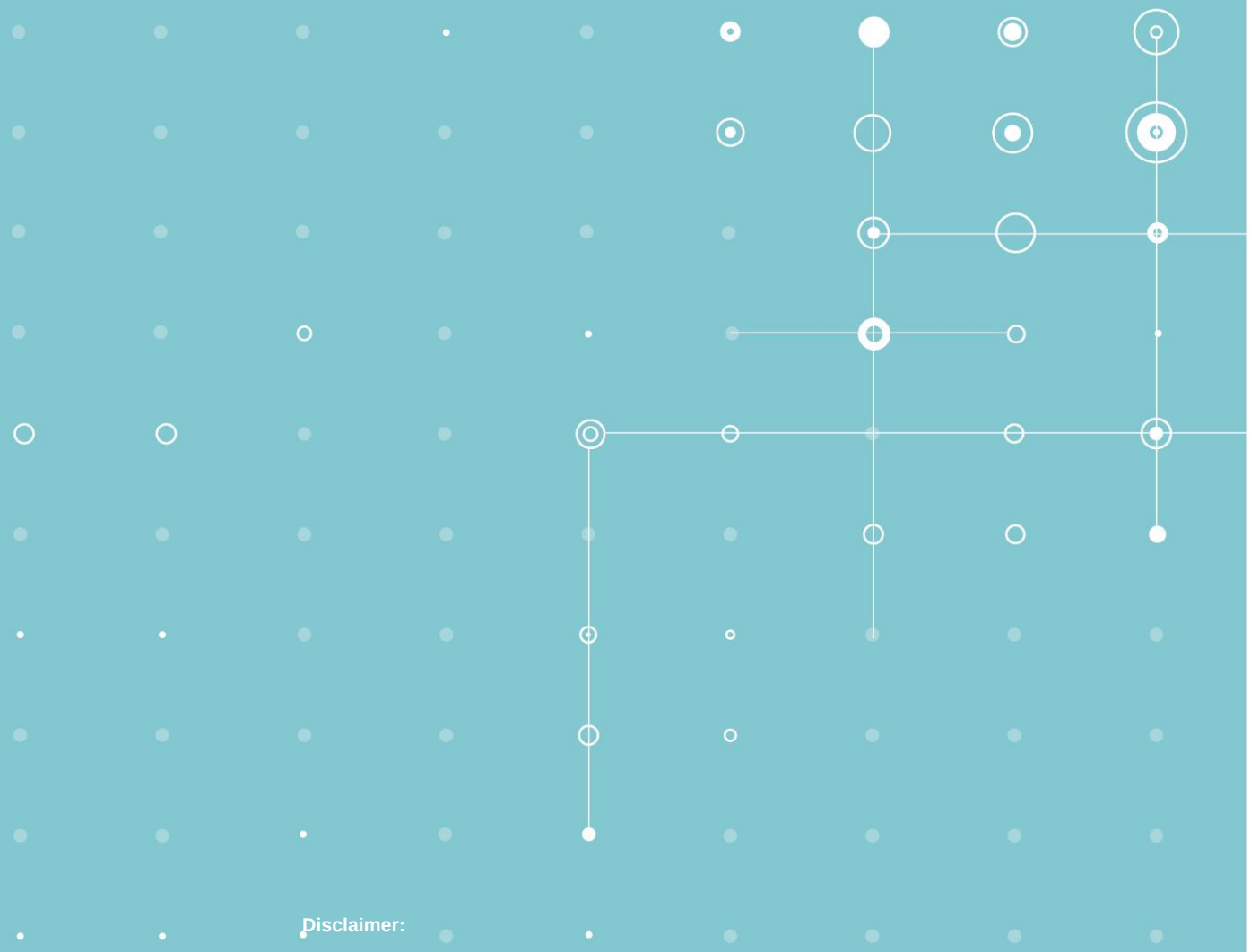
				(use of comparative data if available) • The project is oriented on internal or external benchmarks in order to achieve its effects economically • Regular reflection of the resources used by the project with focus on economically use of resources and cost risks • The overarching costs of the project are in an appropriate proportion to the costs of the outputs			with project manager and financial manager			
		Standard	To what extent could the intervention's outputs (products, investment goods and services) have been increased through the alternative use of inputs (financial, human and material resources)? If possible, refer to data from other evaluations of a region or sector, for instance. (If applicable, this question adds a complementary perspective*) * This case is always applicable in the technical cooperation (TC), please answer the question bindingly	• Use of 'efficiency tool' including instructions and use of the follow-the-money approach as evaluation design (may be combined with other high-quality approaches) • Output level: Analysis of approaches and activities as well as TC instruments (personnel instruments, financing, materials and equipment)[1] compared to possible alternatives with focus on output maximisation (use of comparative data if available) • Analysis of alternative options for allocating resources and shifts between outputs for output maximisation • saved resources can and should be used to maximise outputs • Reflection of the resources during the design phase and regularly during the implementation of the project with focus on output maximisation (with comprehensible justification, changes are certainly desirable for increased efficiency) • 'maximising outputs' means with the same resources, under the same conditions and with the same or better quality					
		Standard	Were the outputs (products, investment goods and services) produced on time and within the planned time frame?							

	Allocation efficiency	Standard	*By what other means and at what cost could the results achieved (higher-level project objective) have been attained?*		Extent to which • the outcome was/could have been maximised with the given resources and project costs were/could have been minimised • the costs vs. achievement of module objective indicators were monitored and considered together for decision-making.	**Evaluation design:** No specific design, the analysis follows the analytical questions from the evaluation matrix based on the GIZ efficiency tool. **Empirical methods:** • Document analysis, • Interviews.	as above plus Faculty Development for Health Professionals and Biomedical Technician Training Project (Dagoye) and Capacity building in fragile settings (GIZ)	• Based on Effectiveness assessment, • no comparison with similar projects and no financial benchmarks.	moderate	
		Standard	To what extent – compared with alternative designs for the intervention – could the results have been attained more cost-effectively?	• Outcome level: Analysis of approaches and activities as well as TC instruments in comparison to possible alternatives with focus on minimum principle (use of comparative data if available) • Regular reflection in the project of the input-outcome relation and alternatives as well as cost risks • The partner contributions are proportionate to the costs for the outcome of the project							
		Standard	To what extent – compared with alternative designs for the intervention – could the positive results have been increased using the existing resources? (If applicable, this question adds a complementary perspective*) * This case is always applicable in the TC, please answer the question bindingly	• Outcome level: Analysis of applied approaches and activities as well as TC instruments compared to possible alternatives with focus on maximising the outcome (real comparison if available) • The project manages its resources between the outputs in such a way that the maximum effects in terms of the module objective are achieved • Regular reflection in the project of the input-outcome relation and alternatives • Reflection and realisation of possibilities for scaling-up • If additional funds (e.g. co-financing) have been raised: Effects on input-outcome ratio (e.g. via economies of scale) and the ratio of administrative costs to total costs • Losses in efficiency due to insufficient coordination and complementarity within German DC are sufficiently avoided						
	(1) see GIZ 2015: 'Integration of TC Instruments – Key Elements', based on BMZ 2014: Handbuch der bilateralen TZ Verfahrensinformation Nr. VI0362014 'Eckpunkte zur Instrumentenintegration'									

OECD DAC criterion Sustainability: Will the benefits last? (max. 100 points) The 'sustainability' criterion relates to continued long-term benefits (at the outcome and impact level) or the probability of continued long-term benefits – taking into account observed or foreseeable risks – over time, particularly after assistance has ended.								
Assessment dimensions	**Filter - project type**	**Evaluation questions**	**Clarifications**	**Basis for assessment / evaluation indicators** *(e.g. module objective/programme indicators, selected hypotheses, or more generally a definition of the aspects to be used for evaluation)*	**Evaluation design and empirical methods** (Design: e.g. contribution analysis, follow-the-money approach) (Methods: e.g. interviews, FGD, document analysis, project/partner monitoring system, workshop, online survey, etc.)	**Data sources** (e.g. list of relevant documents, interviews with stakeholder category XY, specific data, specific monitoring data, specific workshop(s), etc.)	**Data Quality and limitations** (Description of limitations, assessment of data quality: poor, moderate, good, strong)	**Data Quality Assessment** (weak, moderate, good, strong)
Capacities of the beneficiaries and stakeholders	Standard	To what extent do the beneficiaries and stakeholders (individuals, groups and organisations, partners and executing agencies) have the institutional, human and financial resources as well as the willingness (ownership) required to sustain the positive results of the intervention over time (once assistance has drawn to a close)?	• Transitional Development Assistance (TDA) projects primarily address final beneficiaries, whose resilience to crises and recurring shocks is to be strengthened. The focus for TDA projects is thus often on the resilience of final beneficiaries and/or at least the continuity of the measure (see explanation in dimension 3) (clarification in the inception phase of the evaluation).	• Extent to which beneficiaries and stakeholders have the capacity, resources, ownership, and resilience to sustain the results achieved. ('Results' are the current level of achievement of outcome and output indicators.), • Can outputs and outcomes can be linked to other partners or new projects have capacities.	**Evaluation design:** No specific evaluation design applied; the analysis follows the evaluation questions from the evaluation matrix. **Empirical methods:** • Document analysis, • Interviews, • FGD, Chat groups, • Online surveys, • Inception workshop.	**Document analysis:** OCHA reports, patient satisfaction surveys, capacity development strategy, The Long Road to Inclusive Institutions in Libya, costing of the Essential Health Service Package, PCI progress reports, results model (Figure 2), project proposals and project progress reports. **Interviews:** civil society and private sector, partners, GIZ **FGD**: GIZ **Chat:** MHPSS FPs **Inception workshop.**: Discussion of results model	• Standard project documents and humanitarian needs assessments provide good basis for assessment, • interviews may be positively biased, no full capacity assessment available, but biases were mitigated through triangulation of sources and methods.	good
	Standard	To what extent do the beneficiaries and stakeholders (individuals, groups and organisations, partners and executing agencies) have the resilience to overcome future risks that could jeopardise the intervention's results?						

	Contribution to supporting sustainable capacities	Standard	To what extent has the intervention contributed to the beneficiaries and stakeholders (individuals, groups and organisations, partners and executing agencies) having the institutional, human and financial resources as well as the willingness (ownership) required to sustain the intervention's positive results over time and to limit the impact of any negative results?	• Analysis of the preparation and documentation of learning experiences • Description of the anchoring of contents, approaches, methods and concepts in the partner system • Reference to exit strategy of the project • If there is a follow-on project, check to what extent the results of the evaluated project are taken up; the anchoring of the effects in the partner's organisation should be pursued independently of a follow-on project, since sustainability should be achieved even without donor funds • Transitional Development Assistance (TDA) projects primarily address final beneficiaries, whose resilience to crises and recurring shocks is to be strengthened. The focus for TDA projects is thus often on the resilience of final beneficiaries and/or at least the continuity of the measure (see explanation in dimension 3) (clarification in the inception phase of the evaluation).	Contribution of the project to the capacity, resources, ownership and resilience to sustain the results.	**Evaluation design:** No specific evaluation design applied; the analysis follows the evaluation questions from the evaluation matrix. **Empirical methods:** • Document analysis, • Interviews, • FGD.	**Document analysis:** as above plus training plan and results of effectiveness and impact criteria **Interviews and FGD:** as above	• Broad range of project documents to track all activities but only anecdotal evidence on changed behaviours of providers, managers, FPs etc., observation on-site was not possible as planned due to openings hours and timing of visits, • no written exit strategy but a FGD with project team to explore strategy in depth, • moderate evidence..	good	
		Standard	To what extent has the intervention contributed to strengthening the resilience of the beneficiaries and stakeholders (individuals, groups and organisations, partners and executing agencies)?						
		Standard	To what extent has the intervention contributed to strengthening the resilience of particularly disadvantaged groups? (These may be broken down by age, income, gender, ethnicity, etc.)						

	Durability of results over time	Standard	*How stable is the context in which the intervention operates?*		Extent to which the results achieved will be durable over time (prognosis).	**Evaluation design:** Prognosis of the durability of results, based on results achieved; the analysis follows the evaluation questions from the evaluation matrix. **Empirical methods:** • Document analysis, • Interviews, • FGD.	**Document analysis**: as above plus Guiding Framework for Mental Health and Psychosocial Support (MHPSS) in Development Cooperation, project documents Health system strengthening and pandemic prevention in Libya', MHPSS in Libya overview, I**nterviews and FGD** as above	• Due to the fragile context, forecasts are limited and closely linked to the potential impact, •interviews may be positively as well as negatively biased triangulation of methods and sources.	moderate	
		Standard	*To what extent is the durability of the intervention's positive results influenced by the context?*	• Consideration of risks and potentials for the long-term stability of the results and description of the reaction of the project to these						
		Standard	To what extent can the positive (and any negative) results of the intervention be deemed durable?	• Consideration of the extent to which continued use of the results by partners and beneficiaries can be foreseen • Reference to conditions and their influence on the durability, longevity and resilience of the effects (outcome and impact) • In the case of projects in the field of Transitional Development Assistance (TDA), at least the continuity of the measure must be examined: To what extent will services or results be continued in future projects (of GIZ or other donors/organisations) or their sustainability ensured? (Clarification in the inception phase)						



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Deutsche Gesellschaft für
Internationale Zusammenarbeit (GIZ) GmbH

Registered offices
Bonn and Eschborn

Friedrich-Ebert-Allee 32 + 36
53113 Bonn, Germany
T: +49 228 44 60-0
F: +49 228 44 60-17 66

Dag-Hammarskjöld-Weg 1–5
65760 Eschborn, Germany
T: +49 6196 79-0
F: +49 6196 79-11 15

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