
DFID

HEALTH

RESOURCE

CENTRE

Evaluation of links between North and South Healthcare Organisations

Author **John James**
 Chris Minett
 Liz Ollier

Date **May 2008**

DFID Health Resource Centre
5-23 Old Street
London EC1V 9HL
Tel: +44 (0) 207 251 9555
Fax: +44 (0) 207 251 9552

The DFID Health Resource Centre (HRC) provides technical assistance and information to the British Government's Department for International Development (DFID) and its partners in support of pro-poor health policies, financing and services. The HRC is based at HLSP's London office and consists of an international consortium of four organisations: HLSP Ltd, UK; Ifakara Health Research and Development Centre, Tanzania (IHRDC); ICDDR,B - Centre for Health and Population Research, Bangladesh and Sharan, India.

This report was produced by the Health Resource Centre on behalf of the Department for International Development and the Department of Health, and does not necessarily represent the views or the policy of DFID or DH..

Title: Evaluation of links between North and South Healthcare Organisations

Authors:
John James
Chris Minett
Liz Ollier

DFID Health Resource Centre
5-23 Old Street
London EC1V 9HL
Tel: +44 (0) 20 7251 9555
Fax: +44 (0) 20 7251 9552

TABLE OF CONTENTS

ACRONYMS	5
1. EXECUTIVE SUMMARY	7
2. SUMMARY RECOMMENDATIONS:.....	9
2.1. Initiating Links	9
2.2. Governance Issues.....	9
2.3. Donations of Equipment	10
2.4. Planning and Harmonisation	10
2.5. Activities	10
2.6. Regulation and Leverage	11
2.7. Monitoring and Evaluation: Impact on Health Outcomes	11
2.8. Risk Management	11
2.9. Support and Facilitation.....	11
2.10. Models For a UK Links Centre	11
3. BACKGROUND	12
3.1. The Crisp Report.....	12
3.2. Government Response.....	12
4. SCOPE OF WORK OF THE EVALUATION.....	13
5. METHODOLOGY	13
6. CONSTRAINTS.....	15
6.1. Size of Sample	15
6.2. Lack of information	15
6.3. Lack of Quantitative Data: Process Rather Than Impact Indicators	15

6.4.	Difficulty in Making Contact.....	16
6.5.	Obtaining a Country Overview.....	16
7.	PREVIOUS EVALUATIONS	17
8.	PROFILE OF FOCUS LINKS	17
9.	FORMATION OF LINKS	18
10.	MOTIVATION FOR FORMATION	19
11.	GOVERNANCE; UK ORGANISATIONS.....	19
11.1.	Formal Status of the Link.....	19
11.2.	Financial Accountability of Links	20
11.3.	NHS Resources.....	20
11.4.	Governance Relating to Donations	21
12.	GOVERNANCE; SOUTHERN PARTNER.....	21
12.1.	Financial Accountability.....	22
13.	HARMONISATION & ALIGNMENT	22
14.	COMPLEMENTARITY	24
15.	MEMORANDA OF UNDERSTANDING.....	24
16.	SOURCES OF FINANCE	25
17.	VALUE FOR MONEY	27
18.	RISK.....	27
19.	BENEFITS FOR NORTHERN PARTNERS	28
20.	DONATIONS AND EQUIPMENT	29
21.	NON HEALTH BENEFITS.....	30

22. CHOOSING APPROPRIATE LINK PARTNERS; WHICH INSTITUTIONS HAVE MOST TO OFFER?.....	31
23. SELECTION OF LINK ACTIVITIES.....	32
24. INITIATIVES.....	34
24.1. Capacity-building.....	34
24.2. Service Delivery.....	37
25. ARE THE INTERVENTIONS EVIDENCE-BASED?	39
26. IMPACT OF THE INITIATIVES	39
27. SUSTAINABILITY	40
28. MONITORING AND EVALUATION.....	41
29. THE ROLE OF FACILITATING BODIES	41
30. EVALUATION OF SUPPORT MECHANISMS FOR LINKS	42
30.1. Methodology and Scope of Evaluation of Models for Support.....	42
31. ASSESSING THE OPTIONS FOR FUTURE SUPPORT TO LINKS.....	44
31.1. “Managing” Models	45
31.2. “Community” Models	46
31.3. “Minimum Intervention” Models (Facilitation and Support)	46
32. FURTHER CONSIDERATIONS	47
33. THE NEW LINKS CENTRE: CONCLUSIONS.....	48
ANNEX 1: BIBLIOGRAPHY	50
ANNEX 2: PERSONS INTERVIEWED.....	51
ANNEX 3: NORTH AND SOUTH LINKS INCLUDED IN THE STUDY.....	53
ANNEX 4 OVERVIEW OF ORGANISATIONS WHO FACILITATE PARTNERSHIPS OR UNDERTAKE SIMILAR ACTIVITIES.....	60

ANNEX 5 ADDITIONAL FACILITATING AND SUPPORT BODIES	75
ANNEX 6 QUESTIONNAIRE SENT TO UK PARTNERS	77

ACRONYMS

AE	Annual Expenditure
AIDS	Acquired Immunodeficiency Syndrome
AIHA	American International Health Alliance
ARV	Anti Retroviral
BMA	British Medical Association
BTC	Belgian Technical Co-operation
BUILD	Building Understanding through International links for Development
CAP	Coalition Against Poverty (Rhondda Cynon Taff)
CCBRT	Comprehensive Community Based Rehabilitation
CEL	Chief Executive letter (Scotland)
CEO	Chief Executive Officer
CHAM	Christian Health Association Malawi
CHP	Community Health Promoters
CO	Clinical Officer
CSCF	Civil Society Challenge Fund
CVA	Council for Voluntary Action (UK)
DC	District Columbia
DePHE	Development Partners in Higher Education
DFID	Department for International Development (UK)
DGH	District General Hospital (UK)
DIP	District implementation plan
DH	Department of Health (England)
EfH	Education for Health
ESTHER	Ensemble pour une Solidarité Thérapeutic Hospitalièr En Réseau
ETD	Expenditure to Date
EU	European Union
GHETS	Global Health through Education Training and Services
GP	General Practitioner (UK)
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (Germany)
HEI	Higher Education Institution
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information system
HR	Human Resources
HQ	Headquarters
IANA	International Academic Nursing Alliance
IDF	International Development Fund (Scotland)
ICH	Institute of Child Health
IPT	Intermittent Preventative Treatment
KCMC	Kilimanjaro Christian Medical Centre
M and E	Monitoring and Evaluation
MDG	Millennium Development Goal
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non Governmental Organisation
NHS	National Health Service (UK)
OPL	Operational Level Health worker
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief (US)

PHI	Partners in Health Information
PMTCT	Prevention of Mother to Child Transmission
PONT	Health component of Coalition Against Poverty (Rhondda Cynon Taff)
QECH	Queen Elizabeth Central Hospital, Blantyre
RCPS	Royal College of Physicians Scotland
SG	Scottish Government
THET	Tropical Health and Education Trust
TOT	Training of Trainers
TUFH	Towards for Unity in Health
UCLH	University College Hospital, London
US	United States
USAID	United States Agency for International Development
USG	United States Government
UK	United Kingdom
UKOWLA	United Kingdom One World Linking Association
WAG	Welsh Assembly Government
WEEE	Waste Electrical and Electronic Equipment Regulations

1. EXECUTIVE SUMMARY

Background

This report presents the findings of an evaluation of the links between UK health organisations and southern partners. The evaluation was commissioned by the Department of Health and Department for International Development, following the publication of the "Global Health Partnerships" report by Lord Crisp (2007), and the subsequent response by the Government (March 2008). Liz Ollier, John James and Chris Minett, HLSP consultants, conducted the evaluation during April and May 2008.

In summary the evaluation was to:

- Learn lessons from a sample of existing UK–Africa links;
- Examine issues relating to governance and harmonisation;
- Assess the appropriateness of the activities undertaken and their impact;
- Examine the support provided by facilitating organisations;
- Review similar initiatives originating in other countries.

Methodology

In agreement with DH and DFID, the evaluation reviewed a sample of 12 links in three countries – Malawi, Tanzania and Uganda - that focused on MDGs 4 and 5 (maternal and child health). The links were identified from the THET website. We evaluated these links through a combination of: desk reviews of relevant documentation; questionnaires, telephone interviews (and, in some cases) meetings with northern partners; in-country meetings and discussions with southern partner institutions; discussions with southern ministries; discussions with key facilitating organisations involved in establishing links with southern partners. In addition a review of similar initiatives involving other countries was carried out including the role of supporting and facilitating agencies.

Summary findings

- There was considerable variation in the effectiveness of links. Whilst there were a number of successful links, benefiting, and valued by both southern and northern partners, there were also some that had failed to make significant impact and others which had expended considerable resources but not yet got off the ground.
- Links established by individuals with prior experience of working in Africa appeared most successful.
- There were greater impact on outcomes when southern partners determined the nature of the links support provided.
- Continuity of longer-term support provided by experienced UK staff was most valued by southern partners. Multiplicity of short-term inputs (e.g. two week visits) were – with the exception of specifically-requested technical areas – poorly regarded.
- Links are essentially modest, low-cost interventions, focusing principally on capacity building. Hence, in the short-term it is unrealistic to anticipate any demonstrable improvement in health indicators (MDGs, etc). Process, and not impact indicators are more appropriate.
- The role of the facilitating agencies in providing long term and seedcorn funding was appreciated.
- All links should have agreed workplans with agreed outputs signed off by both partners and harmonised with local and national plans.

- Link finances should be administered through transparent mechanisms, and approved by health institution boards.

Where things can go wrong

- Northern partners driving the agenda, and disempowering southern partners (this may be an increased risk with recent UK led proposals to scale up links similar to those evaluated).
- Lack of harmonisation with district and national plans and priorities.
- Slow planning processes – high transaction costs, demands on southern partners' time, opportunity costs, unrealistic plans and promises.
- Technical support provided by UK staff with no prior experience of/ insensitive to the situation in sub Sahara Africa perceived as inappropriate by southern partners.
- Link based on short term visits with multiple players.
- High-technology support: inappropriate in most cases; need to consider opportunity costs, sustainability, and relevance to the situation in sub Saharan Africa.
- Provision of inappropriate equipment and commodities.

Limitations to the review

Whilst this short review was necessarily limited and only a small number of links were evaluated in detail, we found considerable consistency in the responses of southern partners. We had the opportunity to talk to local and national stakeholders (hospital/ district/ government/ local authority/ academic/ NGO) who had wide ranging knowledge and experience of links and this enabled us to draw wider conclusions on the value of links as a development instrument in general.

Recommendations: key elements for ensuring successful links

- Relationship built on friendship, shared values, long-term commitment; “adult: adult” relationship.
- Link conforms with principles of good governance.
- Forum to ensure southern partners determine and drive the nature of the support provided.
- Flexible, iterative approach to developing support.
- Support based, where possible, on existing structures, mechanisms and technical resources.
- Principal focus on capacity building: longer-term visits or attachments by senior staff provide the greatest benefit.
- Minimise transaction costs both locally and nationally by reducing multiple “one off” visits.
- Ensure support based on nationally agreed health packages, policies and protocols and conforms with agreed local curricula.
- Support aligned with regional and national health policy and strategy.
- All support incorporated into institution/ district annual plans.
- Ensure provision of equipment and furniture is demand-led and conforms with guidelines outlined.
- Where possible ensure mechanisms to monitor and evaluate the support given using national data sets (not parallel systems).
- Lessons learned disseminated to other links partners, and to a wider audience.

2. SUMMARY RECOMMENDATIONS:

2.1. Initiating Links

It is strongly recommended that future links should be initiated by southern partners and that they should have the opportunity to “interview” potential partners to make sure that they meet their needs.

There is a strong argument which was put forward by several southern partners and Ministries of Health (MOHs) that suggests that links at all levels may be most valuable on a south to south basis.

links involving a lead person who had experience working in a southern context were most successful as there was knowledge of the context and expectations were matched by reality. Experienced, senior grade personnel who have an understanding of the local context have greater influence than their junior or middle-grade UK counterparts.

2.2. Governance Issues

Given the current lack of clarity about the remit for English Trusts to undertake this work, it seems essential that both executive and non-executive directors approve the link formally and demonstrate transparency over the source of funding and how staff time will be accounted for. There is clearer guidance in Scotland and Wales where link activity is specifically encouraged.

There are undoubtedly benefits to balance the costs of staff being away from their place of work on link visits in terms of education, motivation and social responsibility. It is important that Trusts attempt to measure these in order to be able to respond to any concerns by their members, in the case of Foundation Trusts, or the public.

The added value of links should be recognised in terms of both charitable activities and contributions to the local economies.

It is recommended that all link finances should be administered through a mechanism which allows for transparency and regular external scrutiny. This also protects the individuals concerned. The link should be accountable to the donors of funds and goods and should provide regular financial reports.

Many of the charitable arms of NHS Trusts have a requirement in their constitution that they act to the benefit of the NHS organization or to NHS patients in the location. This might be interpreted that they are acting *ultra vires* if they administer monies which are clearly for the benefit of a southern partner. Under these circumstances it might be better for link funding to be managed through a different mechanism.

It is recommended that all sizable donations of furniture and equipment should be formally approved by Trust boards and their book value recorded in minutes which are available to the public so there can be no misunderstanding about use of NHS resources.

2.3. Donations of Equipment

It is recommended that a code of conduct for donations be drawn up and incorporated in country memoranda of understanding and individual north/south partnership agreements.

2.4. Planning and Harmonisation

A Memorandum of Understanding (MOU) appears to be a valuable mechanism for co-ordination as long as the two parties have some levers for enforcement of good practice. If funding is being provided to northern partners this can be conditional on adherence to certain principles. Likewise the MOU needs to be signed by southern statutory bodies who have leverage through direct accountability to ensure that activities support national and local objectives (i.e not just the MOH but also local authorities and organisations such as the Christian Health Association of Malawi (CHAM) which represents a number of hospitals which have links).

It is important that there is recognition of the conflicting demands on government officials and that contact to inform of impending visits is made through the most time efficient mechanism possible (e.g. through a facilitating agency in-country coordinator or an agreed focal person).

It is recommended that all links should have written and costed annual agreements or workplans, agreed and signed by both parties. These should be reflected in district or hospital annual plans. They should reflect the priorities identified nationally and should complement input from other sources (NGOs, donors etc). In effect the link should aim to fill identified gaps in the southern partner's plan.

It is important that there is transparency about parallel links to the same southern institution so that duplication is avoided.

Links should be careful about undertaking capacity-building which relates to new services, particularly if these do not appear in national essential health packages or local or national plans. There is a danger that these will not be sustainable in the long term or may divert resources away from higher priority activities.

2.5. Activities

Many respondents (including several northern links) commented that longer-term attachments by UK experts provided the greatest benefit, impacting both on technical skills development of staff and on the quality, and management of service delivery.

Hospital based training and capacity building was broadly welcomed by southern partners but it was preferable if there was continuity over a period of time. Multiple "one off" visits by individuals were not found to be as helpful.

Support to service delivery can be both useful in itself and can be used as a vehicle to impart new clinical competences and to strengthen management skills.

It is recommended that northern partners consider making support in management and system development available if southern partners feel it is helpful and appropriate.

There is no doubt that money is best utilised either by staff developing a long term relationship and returning at regular intervals, or by northern staff working for prolonged periods of time in the southern institution. It is very difficult to justify links which do not

have a real focus that is demand-driven or which involve multiple single visits by staff “obtaining an overview”.

2.6. Regulation and Leverage

It must be recognised that many links are funded internally (often by individuals themselves) and there may be no means of providing any form of regulation. Indeed the informal, direct and responsive nature of the partnership is what is most valued by both partners.

2.7. Monitoring and Evaluation: Impact on Health Outcomes

It must be recognized that the majority of links are not service delivery oriented and thus there is unlikely to be direct impact on health outcomes. It is therefore necessary to use process indicators to measure activity and progress. In time, increased capacity should result in measurable impact. Where activities are being undertaken, a baseline survey is essential against which to measure achievement. Wherever possible, existing information systems such as the Health Management Information System (HMIS) data set should be used.

2.8. Risk Management

Most agencies and private companies operating in southern countries in similar environments undertake strict, formal risk assessments and it would seem appropriate that links do likewise.

2.9. Support and Facilitation

Clearly the support and facilitating role of bodies such as THET and PHI are appreciated but it was clear that links could be equally successful without facilitation. Added value from such agencies seem to fall into two areas. First and foremost, the provision of financial support. But northern partners also highlighted a second area – the ability of such agencies to share good practice through workshops and toolkits. This evaluation was not designed to evaluate facilitating agencies and therefore did not examine the value added by the positive convening and advocacy roles such organisations can also play.

2.10. Models For a UK Links Centre

The choice of models for a links Centre is ultimately between:

- A managed model with focused initiatives exerting leverage through financial incentives to ensure that activities are harmonized, complementary, in line with good governance, evidence based and cost effective. This is likely to result in less local ownership and less local financial support through fund raising. It may also mean that initiatives are supply side driven.

Or

- A facilitation and support model which encourages good practice through guidelines and peer pressure, which accepts that there are trade offs between encouraging and supporting enthusiastic (but occasionally less well focused) initiatives which generate additional resources but not having leverage to ensure that the best practice is always followed. This model allows (but does not ensure) demand driven initiatives.

3. BACKGROUND

3.1. The Crisp Report

The Crisp report, *Global Health Partnerships*, identified a number of areas where the UK and developing countries could mutually benefit from working together. The main points were as follows:

- Developing countries should lead and own their solutions.
- The UK health economy should add value to DFID's development work, supporting the scale-up of training, education and employment of healthcare workers in developing countries.
- More work was needed to identify and share good practice.
- The UK should build on the strengths of existing efforts.
- The UK Government should encourage a more strategic and coherent response.

The report highlighted lack of trained health workers (a global shortfall of 4.2 million) and inadequate health systems as crucial barriers to reaching the Millennium Development Goals and made the case for the UK to scale up its international availability of institutional and professional expertise and to do so more strategically.

Within the report, Lord Crisp recognised the work undertaken by UK health organisations supporting links, and the work of agencies such as THET in providing facilitation and support. The report recommended that the government should: "*Commission an evaluation of the potential impact of partnerships to understand what works, where and why.*" This evaluation is a direct result of that recommendation.

3.2. Government Response

The government response to the Crisp report was published in March 2008 following extensive consultation.

In section three, the government indicates commitment to fund a single "one stop shop" in the form of an agency or consortium with a signposting function for information for both UK and overseas countries. There are a number of organisations that currently undertake activities in this area, including THET, Partnerships in Health Information (PHI), Optin, the Anglican Church as well as the Scottish and Welsh administrations.

In section 8, with reference to links between UK health organisations and overseas partners, it states:

"We agree that more work is needed to build the evidence base around these partnerships. Despite many positive anecdotal reports, there is still insufficient understanding on the impact and benefit of these links on the UK and developing partners. DFID and DH are currently funding an independent evaluation of the impact of international health links. The work will build on work that THET is currently doing to evaluate its partnerships. Our plan is to use the results of the evaluation to establish a Health Links Scheme that complements the existing DelPHE and community links schemes. We anticipate that this would work as a challenge fund, providing support over three years to establish and develop such links with developing country partners.

4. SCOPE OF WORK OF THE EVALUATION

The evaluation was undertaken as a direct result of the government response. It focuses on:

- Learning lessons from a sample of existing links in three countries.
- Examining issues relating to governance and harmonisation including complementarity with other initiatives.
- Attempting to provide some assessment of the appropriateness of the activities undertaken and their impact.
- Examining the support provided by facilitating organisations.
- Undertaking a scoping of similar initiatives originating in other countries and identifying lessons.

In undertaking this evaluation it was clearly important to balance scope and depth against time available and cost. Whilst it is not possible to be definitive about the number of links in existence, one of the larger facilitating organisations, THET maintains information on approximately one hundred and fifteen links and there is general agreement that there are approximately one hundred and thirty major formal partnerships in the UK.

A decision was made not to look at the links undertaken by individual clinicians. They tend to be small-scale and do not attract funding from their Trust board or from seedcorn grants from other organisations, or receive support through major national charitable bodies such as Comic Relief. It was agreed that the focus should be confined to formal institutional links (i.e hospital to hospital, GP practice to District). These were identified using a database from one of the facilitating agencies; THET's database was selected for this purpose.

A scoping exercise undertaken prior to the evaluation suggested a methodology for identifying which links to look at in detail across three countries. The countries were chosen on the basis of the number of known partnerships (so that the cost of visits could be justified by the number of links seen). They were also chosen on the basis of proximity to one another to minimise travel costs.

In each country there were many links to choose from and it was important to use a methodology which "felt fair" and was not guided by anecdotal reports of achievement. It was therefore broadly agreed to look at links which appeared to undertake a proportion of their work in the field of maternal and child health. Many links undertook other work as well and the marker condition selection approach did not mean that there was purely a focus on the marker specialties. Indeed, when visited, many of the links had workplans where other priorities had developed and child and maternal services no longer featured.

5. METHODOLOGY

Links cover a wide range of functions and clinical specialties. In general links can be divided into those which build capacity and those which support service delivery. Many

of the links focus on specialties for which information is unlikely to be collected by southern partners (mental health, cerebral palsy, epilepsy etc). Others relate to surgical procedures where activity data alone gives some indication of impact (number of staff trained, number of surgical procedures performed etc).

It was agreed that in order to achieve a reasonably comprehensive estimate of impact, a suitable marker speciality should be chosen. Links which undertake work in this field should form the focus of the impact study. Maternal and child health was felt to be appropriate for the following reasons.

- MDGs 4 and 5 target maternal and child health.
- There is international consensus on appropriate interventions and capacity building.
- Most countries collect information relating to maternal mortality and under-five mortality.
- A number of links include maternal and child health in their workplans.
- It is a marker which should show signs of improvement in a relatively short time period.
- It is a marker where improvement is likely to reflect changes in the whole health system, as effective delivery requires an integrated, and not just vertical, approach.

There was, inevitably, an issue regarding attribution given the major push on the MDGs in most countries, but this was felt to be unavoidable. Furthermore, many links are involved principally in training and capacity building; whilst this may impact on indicators, the anticipated improvements would be demonstrated in the longer term.

In looking at activities under the link the study attempted to gain information as follows:-

- The activities that have taken place (number of staff trained, protocols developed, initiatives on improving access etc).
- Whether the activities, protocols and procedures accord with accepted international practice (for example with the interventions documented in the Lancet series on maternal, neonatal and child survival, 2003 – 6).
- Whether the activities have focused on service delivery or transfer of skills and knowledge.

To assess the “added value” of the link work:

- Is the link building capacity within its partner organisation?
- Has there been any detectable impact on maternal and child mortality indicators at institutional level over the period of the link (or other partnership focus area)?

This evaluation differed from previous evaluations in that it focused particularly on issues of governance and harmonisation and also looked at similar initiatives involving institutions in Europe, the United States and Australia.

The governance and harmonisation issues were evaluated by:

- A questionnaire completed by northern partners (plus some follow up telephone calls).
- Interviews with southern partners.
- Meetings with ministries of health.
- Meetings with donor representatives (including DFID) in the three focus countries.

The review of similar partnerships in other countries was undertaken through a literature and web search together with telephone interviews.

6. CONSTRAINTS

6.1. Size of Sample

The major constraints on the methodology have inevitably been time and cost. It was only possible to look at a small number of links. No sample can be truly representative, and only looking at links in East Africa may not identify any regional differences that may exist. However, the links chosen varied widely and covered both those facilitated/supported by THET, PHI, DeIPHE and the Scottish and Welsh Assemblies. Several southern partners included in this study were found to have other links - with the UK, with Europe or with the US - so the opportunity was taken to learn from these also.

6.2. Lack of information

All UK partners responded to a written questionnaire (Annex 6) although not all questions were answered. In general these related to governance and harmonisation. It was not always possible to ascertain, even with follow up telephone interviews, whether this stemmed from a lack of understanding of aid modalities and the principles of harmonisation or whether the topic just had not been taken into consideration.

6.3. Lack of Quantitative Data: Process Rather Than Impact Indicators

Many links changed their activities over time. Even where the focus was on specific activities, the objectives were rarely clearly articulated, or baseline information determined. Quantitative evaluation, therefore, proved very difficult. It was interesting that many UK partners stated that no information was available and seemed unaware of national data sets which could be utilised to measure progress. Furthermore, as most southern links were receiving support from multiple sources, attribution to a specific intervention or programme of interventions undertaken in conjunction with a UK partner becomes even more complex.

Despite the evaluation team's attempts to obtain quantitative indicators of progress, in almost all cases, impact could only be measured in terms of activity (people trained, systems developed). There was little or no follow up on whether new competences were being used and what impact this had on individual or community health.

However, there were a few examples where new techniques had been taught and an audit of patient outcomes had been agreed, for example in Kilimanjaro Christian Medical

Centre (KCMC) an audit of laparoscopic interventions was agreed following training, including patient recovery rates, post operative infection, requirement for rehabilitation and cost comparison against conventional surgery) and it was possible to use routinely collected data to identify impact in at least one link (PONT/Mbale).

It must be recognized that the majority of links are not service delivery oriented and thus there is unlikely to be direct impact. It is therefore necessary to use process indicators to measure activity and progress. In time, increased capacity should result in impact.

6.4. Difficulty in Making Contact

Despite numerous efforts to make contact with lead managers at Nkhosakota hospitals in Malawi, no response was received to emails and telephone numbers did not function. Reluctantly, therefore, just before arriving in Malawi, the proposed visit was omitted from the itinerary (it involved considerable travel) as there was no certainty that a meeting would take place. The time was reallocated to visiting other links, to meeting the national THET coordinator as well as the local “ambassador” for a Scottish initiative.

6.5. Obtaining a Country Overview

In Tanzania there is a specific agreement that development partners will minimise meetings with government officials during specific periods and the evaluators’ visit coincided with one of these. The Director of Hospital Services kindly agreed to provide information but the evaluators were unable to obtain input in respect of District level links. Likewise in Uganda it was possible to have a meeting with the Commissioner of Clinical Services (responsible for all referral hospitals) but devolvement of district level services to local authorities meant that this department could not provide a comprehensive overview. In Malawi all senior managers in the Ministry had been called away unexpectedly but it was possible to meet the DFID- funded technical assistant working on the SWAp.

In each of the countries visited, there is a policy at ministerial level to reduce transaction costs related to meeting visitors due to the huge potential loss in productive time. It is of concern that none of the link partners seemed aware of these policies and some had undertaken a large number of visits at national, regional and local level. **It is important that there is recognition of the conflicting demands on government officials and that contact to inform of impending visits is made through the most time efficient mechanism possible.** THET has reached agreement that a senior government official in Uganda provides a single point of contact for links and has piloted the use of a designated co-ordinator in Malawi, and this is clearly helpful in this respect. However, the time commitment may be substantial. Both coordinators combine this work with important full time public sector roles and it is important that this additional workload does not impact on their prime responsibilities.

Although the evaluators were able to study strategic priorities through the planning documents, none of these referred specifically to links. They did however provide information on the priorities for the health sector. It was therefore possible to compare national and local priorities as shown in strategic and operational plans with activities being undertaken under the links.

7. PREVIOUS EVALUATIONS

The Department of Health commissioned a survey of international health links involving English Trusts in 2005. This was purely based on a questionnaire and it summarised responses from 129 organisations out of the 508 contacted.

THET undertook a major evaluation in 2007(*Making an Impact*). It was undertaken by two researchers, took several weeks and resulted in a substantial document. It originally planned to look at the impact of all links but an estimation of the work involved in reading documentary evidence and conducting interviews resulted in the work being confined to six links, all of which were in Africa.

The evaluation aimed to be both quantitative and qualitative but, as recognised in the report, tended to be fairly anecdotal and descriptive. This was because, in general, there was no baseline survey to compare against, no Monitoring and Evaluation (M and E) indicators and the focus of work for each link varied over time based on the expressed need of the southern partner. The links were chosen to include well established links as well as newer ones. A judgment was made to obtain information only from documentation and by interview with the UK partner although the limitations of this methodology were recognized. This was a pragmatic decision based on cost and practicality.

The resultant report is strongly focused on a qualitative analysis of delivery and impact. It does not cover aspects of governance, harmonization or cost effectiveness to any great extent. It recognizes its own shortcomings however and makes a number of sensible recommendations to improve both management of links, but also M and E processes for the future.

A number of links have been given funding to undertake evaluations of their work but this did not apply to the partnerships that were studied.

This evaluation built on the experiences from the previous evaluations in the following ways

- It used questionnaires to elicit information from northern partners, avoiding interviewer bias.
- It collected information from southern partners on both their experience of the link process, but also activities and impact.
- It looked beyond the UK experience to attempt to identify useful models for links.

8. PROFILE OF FOCUS LINKS

The links chosen differed significantly; twelve links were studied but only eleven southern partners were visited (it was not possible to make contact with one). Although all appeared to be institutional links, three were largely run outside the hospital structure and three were not aligned with a single institution but brought together several health

institutions. Institutional partners included both Trusts and Foundation Trusts (secondary and tertiary) but also primary care practices. No PCT links were evaluated.

- One link was part of a community to community link.
- One link involved a professional association.
- Two links related to access to information.
- One link was primarily involved with a single specialty.
- Two links were relatively new and, of these, one had not yet obtained any long term funding.
- One link was of very long standing (over twenty years).

This diversity gave a reasonable overview of different models of partnership and appears reasonably representative.

9. FORMATION OF LINKS

It proved surprisingly difficult to ascertain the origin of some organisational links. Whilst some (Feet First/ Lilongwe Central Hospital, Northumbria/KCMC) originated from a clinician who had worked in the location, many appear to have started through a chance encounter at a conference, as part of a period of study in the UK (Muhimbili) or a visit whilst on holiday. Two followed periods of voluntary work which established contacts. Some are clearly a development of a research relationship (Oxford Radcliffe and Kilimanjaro/ UCLH and Mulago) and several originally started through church contacts (QEMC Blantyre and Birmingham, PONT – Mbale CAP, Atatur and Sheffield). None of the partnerships studied was originally brokered through THET although they had encouraged the Mulago/ UCHL and Nkotakota/ Coventry and Warks links. None appeared to have been initiated by a southern partner.

Whilst some links appeared to be between organisations of similar size and function (Birmingham Children's Hospital with QECH Paediatric Department, Blantyre/ University College Hospital London Tropical Medicine with Mulago Hospital Kampala) this is not always the case. Some smaller hospitals in the UK are partnered with national referral centres and some UK University teaching hospitals with District hospitals. This is likely to make understanding the context more difficult for both parties.

Whilst at least one northern partner visited several potential link organisations before choosing a counterpart, there was no evidence that any of the southern partners had the opportunity to select their own link from a range of potential partners. However the Scottish / Malawi link focussing on health clinics did employ a local "ambassador" to identify potential partner sites.

It is recommended that southern partners be encouraged to initiate links and to choose the partner who has most to offer them.

10. MOTIVATION FOR FORMATION

In each case studied the motivation for the partnership included a number of factors but social responsibility featured highly. However, the opportunities for overseas study and the chance to participate in training activities also reoccurred frequently. It was noticeable how many of the links started through a single energetic and motivated individual. In many cases this person had previous experience of working long term in the region and it seemed that these **links were most successful as there was knowledge of the context and expectations were matched by reality.**

11. GOVERNANCE; UK ORGANISATIONS

11.1. Formal Status of the Link

Whilst there is a significant amount of activity in the UK involving links between NHS organizations and overseas partners, the framework for legitimizing this has not always been clear. The government response to the Crisp report undertakes to produce a framework which confirms government support for all health related bodies to have the opportunity to participate. However, there is documented guidance in Wales, through the Welsh Health Circular (2006) 070, and Scotland has used Chief Executive's Letters (CELs) to provide direction and guidance on international involvement.

Currently the statutory framework under which Trusts and Foundation Trusts have been created leaves the issue of working with international partners less clear. Foundation Trusts have "a primary purpose of providing NHS care to NHS patients. They are required in law to use their assets – such as land and buildings – to promote their primary purpose of providing NHS services to NHS patients" (a Short Guide to NHS Foundation Trusts) In most cases this has meant that Trusts have undertaken their links through setting up specific charities or operating through their Charities / Trust Funds Committees but this is not universally the case.

Not all links have obtained the formal agreement of their governing body (usually the Trust Board). In some cases there appeared tacit agreement (a typical comment was "The CEO of the Trust is aware and approves of this work") but only in a minority of cases (four) was there minuted board approval. Although some of the links were Foundation Trusts, none mentioned their members although one link had a non-executive director on their link Board.

Given the current lack of clarity about the remit for English trusts to undertake this work, it seems essential that both executive and non-executive directors approve the link formally and demonstrate transparency over the source of funding and how staff time will be accounted for.

"A business case for the link was first agreed by the Trust Board in March 2006. It is fully supported by the Charitable Funds Committee, a sub committee of the Board. The link was accepted as a formal country to country institutional link by the Trust Board on 27th March 2008. Minutes of both meetings are available.

Link activities are reported quarterly to the Charitable Funds Committee which reports to

the Trust Board. An annual overview is prepared for the annual charities report to the Trust Board and Charities Commission”

Northumbria

Where other health organisations have developed partnerships, the governance framework appears to have varied. In the example of the PONT link, the health component which involves both a hospital and a primary care practice has been one element of a wider community initiative (involving support to OVCs, animal husbandry, education,) and funds are currently channelled through the community PONT fund. This is currently applying for independent charitable status. Grants from the Welsh Assembly are being disbursed through the Local Health Board.

11.2. Financial Accountability of Links

Eight of the links studied process their funds through a charity they have established for the purpose, or through the organisation's own charity/ trust funds mechanisms. One link was using resources held by PHI and one had not yet got any resources. One link studied was holding funds raised, together with a seedcorn grant, in personal bank accounts. Although the sums concerned were very small (approximately £6,000 in total) and this was considered a temporary arrangement, it does not appear to be adequately transparent nor in line with THET guidelines.

If finances are processed through a formal charity then this will entail a regular report to the Charity Commission. In addition some Trust Boards have adopted the good practice of receiving a periodic report on income, expenditure, activities and impact. However, this is not universal.

Many of the charitable arms of NHS Trusts have a requirement in their constitution that they act to the benefit of the NHS organization or to NHS patients in the location. This might be interpreted that they are acting *ultra vires* if they administer monies which are clearly for the benefit of a southern partner. Under these circumstances it might be better for link funding to be managed through a different mechanism.

It is recommended that all link finances should be administered through a mechanism which allows for transparency and regular external scrutiny. This also protects the individuals concerned. The link should be accountable to the donors of funds and goods and should provide regular financial reports.

11.3. NHS Resources

None of the links were financially supported from local NHS revenue and this would currently not be appropriate given the legal framework in England. The situation is somewhat different in Scotland and Wales (see Section 11).

The major real cost to NHS organisations is in terms of staff time. Whilst some Trusts have a formal written policy on how staff should account for their time, this is neither universal nor consistent. Some staff are given study leave, some have “special “ leave whilst the majority take annual leave (at least in part) in order to participate. Study leave

is paid time away from the Trust which may require paid cover. Only one link accounted for replacement costs.

There is therefore undoubtedly a significant cost to the Trust. Two weeks of consultant time will cost the Trust approximately £6000 and may also jeopardise the Trust's income. This is particularly true in those specialties such as orthopaedics where Trusts are finding it difficult to meet both local agreements but also national targets. Providing cover will cost at least a similar sum. Many links are sending out three to four staff for up to 4 weeks a year.

There are undoubtedly benefits to balance the costs of staff being away from their place of work on link visits in terms of education, motivation and social responsibility. It is important that Trusts attempt to measure these in order to be able to respond to any concerns by their members, in the case of Foundation Trusts, or the public.

11.4. Governance Relating to Donations

A number of links involved donation of "redundant" medical equipment and furniture to the southern partner. In some cases this was estimated to have a value of several hundred thousand pounds. In two links studied these donations were resultant on hospital closures.

Given the high stated value, the team investigated one of the donations with the Trust concerned. There was a significant difference between the value quoted by the links team and the book value to the Trust. In this case, efforts had been made to reallocate the items, they had been inspected for resale value and had been removed from the asset register with a book loss of no value. The goods were shipped to the recipient country at the southern partners' expense.

"It actually saved us money to dispose of it this way...otherwise we would have had to pay to get rid of it".

Northern partner

It would be expected that a donation of this size would be processed through the Trust board and minuted, and on investigation this was indeed found to be the case.

It is recommended that all sizable donations of furniture and equipment should be formally approved by Trust boards and their book value recorded in minutes which are available to the public to avert possible misunderstandings about use of NHS resources.

12. GOVERNANCE; SOUTHERN PARTNER

It proved more difficult to identify the governance framework for southern partners. In part this was due to there being a range of different organisations involved including:

- District hospitals and health services accountable to local authorities.

- Non public sector hospitals (including those run by church organisations).
- Referral or Tertiary hospitals accountable to the respective Ministry of Health
- Academic institutions.
- NGOs.

Many of the southern partners had links with a number of institutions and one had an international liaison officer (KCMC, Tanzania). In general, links were led by the senior manager (CEO, District Director of Health Services, Chief Librarian) or by a head of a clinical department and many were clearly supported by their local Board or management team but there did not appear to be mechanisms for formal approval by the local authority or the MOH.

Uganda provides a good example. Districts were devolved to local authorities under the 1997 Local Government Act. This Act states: "For purposes of ensuring implementation of national policies and adherence to performance standards on the part of Local Governments, Ministries shall inspect, monitor and shall where necessary, offer technical advice, support supervision, and training within their respective sectors." Given that the majority of links have a substantial input to training activities it would seem important that the MOH is aware of all links. Whilst the MOU between the MOH and THET (see section 13) provides a mechanism whereby information on links is provided by UK partners there seems no internal mechanism which would also cover partnerships involving other countries.

12.1. Financial Accountability

In general, grants are held by northern partners although, in at least one case, the northern party had offered to set up a local bank account with a southern signatory. Where expenditure is incurred which relates to the southern partner (tickets to UK, etc.) this is normally arranged through a UK travel agency and paid for in sterling.

13. HARMONISATION & ALIGNMENT

All three countries visited have current strategic plans which identify priorities for the health sector. There are well developed mechanisms for donor harmonisation and contributing donors have agreed programmes which support national priorities either through budget support or through harmonised interventions. This is in line with international practice and follows the Paris Declaration on Aid Effectiveness which is supported by DFID. This incorporates the principles that:

- Donor countries will base their overall support on receiving countries' national development strategies, institutions, and procedures.
- Donor countries will work so that their actions are more harmonized, transparent, and collectively effective,

In each country, there are agreed protocols which identify the relationship between the Ministry of Health and development partners. In some cases, including Tanzania, this is formalised into a Joint Assistance Strategy (2006) covering all public sectors which is very specific about the need to align all activities with national and sector plans,

strategies, policies and programmes and local government plans. This means agreeing workplans in a way which not only follow agreed priorities but also coincides with the Government Calendar of Processes and also respects agreed “quiet times” when development partners will minimise interaction to allow for planning and budgeting activities.

It was widely recognised that not all links were aware of the need to harmonise and align, and questionnaires and interviews revealed that very few had made efforts to ensure that activities were in line with local and national priorities or coherent with the activities of other development partners. This is, of course, a responsibility for both partners in a link. It was identified by both government officials and development partners that there is currently little leverage to persuade health partnerships involving northern partners from a variety of countries to bring their activities into line.

Effective harmonisation implies also aligning activities behind partner leadership, and capturing the totality of inputs. In Uganda, whilst the sums are small, finance and other inputs undertaken under links are currently “off budget”. This is partially because support can currently only be recorded if it involves a ministry, department or agency. There is a move to record non governmental budget finances “for information” in future and the view was expressed that links should be included.

Whilst there were no examples found of activities which worked against country plans, many initiatives involved services which were not explicitly a priority. In many cases this involved building capacity of link staff. It is difficult to be explicit whether this should be encouraged or discouraged. On the one hand staff are acquiring new skills and certainly appear more motivated as a result. On the other there is an opportunity cost in the time taken for training but also in the subsequent use of time and resources practicing this new skill. Whilst links were supporting infrastructure cost (new items of equipment, etc.) none were funding the revenue consequences of what are, de facto, service developments. **Links should be careful about undertaking capacity building which relates to new services, particularly if these do not appear in national essential health packages or local or national plans. There is a danger that these will not be sustainable in the long term or may divert resources away from higher priority activities.**

THET recognises the need to move towards greater harmonisation and alignment, and the Memorandum of Understanding (MOU) signed with the MOH in Uganda is a first step in this direction. It explicitly states that link activities should be in line with government policy. It does not however encompass the need to ensure that both planned activities and financial inputs should be incorporated in District/ hospital plans.

It is recommended that all links should have written and costed annual agreements, agreed and signed by both parties. These should be reflected in District or Hospital annual plans. They should reflect the priorities identified nationally and should complement input from other sources (NGOs, donors etc) In effect the links should aim to fill identified gaps in the southern partners plan and do so in accordance with the principles of the Paris declaration.

14. COMPLEMENTARITY

Almost all the southern organizations were receiving support from multiple sources. Although no evidence of duplication was found, it was interesting that few of the northern organisations were aware of other support mechanisms including those provided by donors, NGOs or other partners. This suggests either that they are not being reflected in institutional or District plans or that northern partners are not sharing these plans.

It is important that there is transparency about parallel links to the same southern institution so that duplication is avoided.

15. MEMORANDA OF UNDERSTANDING

There is a recognition that one way of moving towards greater harmonisation and alignment, ensuring that links work in a complementary way, is through an MOU. The evaluation team received a copy of the MOU signed by THET in January 2007 with the Ministry of Health in Uganda which is understood to be similar to a model used with other countries.

Whilst clearly valuable in that it attempts to provide a mechanism for initiating partnerships as well as a co-ordination and evaluation framework, it does not, as yet, seem to be fully achieving these goals. The MOU would appear to have a number of omissions including the need to have an agreed annual workplan which is incorporated in District health plans, the need to conduct a base line survey in order to undertake evaluation and there is no mechanism for ensuring goods and equipment provided are appropriate and respond to a specific request.

It was not clear to what extent the MOH has an understanding of the current links. It seems certain they are not currently monitoring them and are not in a position to provide overview, as neither the UK nor local partners are routinely informing them of visits and activities. One of the reasons for this is because some links are at District level which is accountable to the local authority not the MOH. In principle, it should, however, be possible to have oversight through planning and supervision systems.

A Memorandum of Understanding appears to be a valuable mechanism for co-ordination as long as the two parties have some levers for enforcement of good practice. If funding is being provided to northern partners, this can be conditional on certain principles being adhered to. Likewise the MOU needs to be signed by southern statutory bodies who have leverage through direct accountability to ensure that activities support national and local objectives (i.e not just the MOH but also local authorities and organisations such as the Christian Health Association of Malawi (CHAM) which represents a number of hospitals which have links).

It must be recognised that many links are funded internally (often by individuals themselves) and there may be no means of providing any form of regulation. Indeed the informal, direct and responsive nature of the partnership is what is most valued by both partners.

"If we had to jump through bureaucratic hoops we wouldn't be doing this".

"One of the great benefits of not being funded by organisations is that we are spared much paperwork."

Northern partners

Whilst every effort should be made to encourage harmonisation, it must be recognised that some of these links undertake activities at no cost to the public purse in the UK nor to the southern country, which are based on good intentions and which are providing additional benefit to communities.

It is difficult to balance the need for harmonisation against the risk that some links would not continue if the processes become too onerous. As long as they are not diverting resources (including the workforce) away from agreed national and local priorities, it should be recognised that this is an additional resource which otherwise would not be available. In which case the principal of "do no harm" may be appropriate. In any event there is little or no leverage which can be asserted.

16. SOURCES OF FINANCE

Links are funded through a wide range of methods but the principle source appears to be voluntary fundraising and personal giving by northern link staff. In many cases this is through using their annual leave but a significant number pay their own airfares and accommodation.

In general the sums of money for links are small and the contribution from public sector/government funds is smaller still. The following table provides a summary based on information provided by the UK institutions.

Link	Annual Expenditure (AE) or Expenditure to date(ETD)	Source
Birmingham	£26,000 (ETD) £5000 essential equipment	Grants from medical organisations Trust funds Individual donations Fundraising Contribution from diocese
Royal College of Obstetricians and	Not available	Funded by DFID through British Council 2002-2005

Gynaecologists		when supported by PHI Funding for health corners project not yet secured (DELPHE)
Coventry and Warwickshire	Not available	Seedcorn funding from THET Charitable fundraising Equipment following hospital closure
Blackpool	£5-8,000 per visit	Seedcorn grant from THET Grant BMA Parthenon Trust RCPS Glasgow Donations fundraising
Hospital for Tropical Diseases (UCLH) and Womens Health Institute	£15,000 £10,000 £2500 £40,000	Various sources HTD for start up costs Interserve THET (seedcorn) UCLH Charitable Trust (for 2008 onwards) Equipment following closure of Middlesex Hospital (2005)
Oxford Radcliffe	Not available	All self funded except for grant from ICH for travel for 5 yrs (one paediatrician)
Hereford	£10,000(AE) Fares from UK self funded	Cost of four visitors plus 2 containers of goods Donations Fundraising Donations in kind
Northumbria	£ 15K pa 2001-6 £23,000 (AE estimate)	Initially funded by DFID Now by fundraising Underwritten by Trust
Pontypridd	£47,800 (2007)	All visits self funded Grants from WAG Community based fundraising
Pearl of Africa/ Sheffield	Estimated £5000 (ETD)	THET (£2000) Fundraising Self funding
Surrey, Sussex Healthcare Trust	£3000 ETD	DFID PHI Dreyfus Foundation Fundraising
Scottish Primary Care Group (southern Malawi)	£94,000	Grant from Scottish administration

17. VALUE FOR MONEY

It is difficult to assess value for money given that much of the resource utilised is a “free good”. It must be acknowledged that many NHS staff are travelling at their own expense and in their own time to undertake partner activities. It is not therefore a matter for public debate if they choose to do this, even if there is a view that this resource could be used better. Value for money must be judged differently depending on the aims of the link; those which are primarily involved in service delivery may actually prove very expensive on a case by case basis once overhead costs are taken into account but, if they also include a strong training function, this needs to be taken into account and may compare very favourably to providing courses in country or attachments overseas.

Certainly the formal investment in links is relatively small even for the Scottish and Welsh links which are comparatively better funded. It is difficult to assess the productive time involved in exchange visits. Some links involve individuals who have a long association and an in depth knowledge of context and they appear to spend a significant portion of their time undertaking service delivery and/ or capacity building activities. However some links have involved numerous visits involving a variety of people many of whom have no knowledge or experience working in a southern environment. Much of their time involves gaining an overview and their ability to deliver meaningful contextualised training is limited. These are expensive and result in little actual benefit beyond friendship. Clearly **it is very difficult to justify links which do not have a real focus that is demand driven or which involve multiple single visits by staff “obtaining an overview”.**

There is no doubt that money is best utilised by either staff developing a long term relationship and returning at regular intervals (such as the Blackpool/ Lilongwe Central Hospital which involves both service delivery in orthopaedics but also training in trauma and the Northumbria/KCMC which involves surgical training) or by northern staff working for prolonged period of time in the southern institution (Birmingham Children’s Hospital were able to release two nurses to work in Queen Elizabeth’s Central Hospital, Blantyre for six months).

“We found that we had a great deal to learn about nursing in a developing country before we were confident enough to begin teaching”.
Birmingham.

18. RISK

None of the institutions interviewed provided information on managing risk. In response to a specific written question a minority of northern link partners provided travellers insurance but only two had considered the need for indemnity insurance even where there were direct clinical activities (only one link could demonstrate medical indemnity insurance for work undertaken). In general, there were mechanisms in place for registering UK clinicians in the southern country and exchange visitors to the UK did not take part in clinical activity.

No form of formal risk assessment could be identified despite the fact that some southern partners were situated in environments subject to climatic extremes, poor infrastructure and occasional civil unrest. The biggest risk to staff almost certainly relates to travel in country where road traffic accidents are common.

Nor was there an assessment of reputational risk despite northern partners occasionally treating patients under less than optimal conditions.

It was reported that a surgeon (not from the UK) participating in a partnership has sadly experienced a death to a patient operated on. Although he was not necessarily negligent he had left the country concerned because of both physical danger from the community but also potential arrest by the authorities. This was damaging both to his personal reputation but also to his employing hospital. In other circumstances he might also have faced legal action for damages.

Although the majority of money is held in the UK and used for direct costs such as flights, there are some examples where UK partners have set up bank accounts or transferred funding to the southern country. Apart from risks of fraud or misappropriation there may also be risks relating to exchange rates and international financial transfers which need to be assessed and managed.

Most agencies and private companies operating in similar environments undertake strict formal risk assessments and it would seem appropriate that links do likewise.

19. BENEFITS FOR NORTHERN PARTNERS

In the survey of English links undertaken in 2005 by Dr Andrew Furber, there was an attempt to ascertain the perceived benefit to Trusts. The survey received 129 responses out of the 508 Trusts sent questionnaires (response rate of 25.4%). Given this low response rate it seems likely that there may be some bias towards links which were perceived as successful. The responses were as follows:

Response	Number of Responses (total 129)
Cross cultural awareness	57
Individual personnel development	51
Staff motivation	45
Learning new ideas relevant to the Trust	39
Team building	26
No perceived benefit to organisation	3
Other	12

“Other” included better use of scarce resources, greater appreciation of NHS, staff review own practice, cultural experience, develop management structures, improving relationships with the local (ethnic minority) community, good public relations, financial income (for commercial aspects), enabling ‘out of the box’ thinking and encouraging philanthropy.

A similar question was asked in this evaluation. The responses were very similar although no organisation felt they were getting no benefit and two other factors were frequently highlighted. One was that staff and organisations had a greater understanding of overseas development needs and a clearer idea how they could contribute meaningfully. Several links mentioned that they now understood the importance of support being based on a model of mutual benefit and equality rather than one organisation “doing good” to another.

Secondly, several links reported that staff had gained a greater knowledge of tropical diseases and their prevention and treatment. Whilst this may be a matter of personal satisfaction it is unlikely that this is a competence that their organisation has prioritised, particularly as the northern partners who reported this do not have significant immigrant or highly mobile populations within their catchments.

Improved recruitment and retention was also identified but, perhaps unsurprisingly, there appeared to be no data to support this. If there is an effect, it is most likely in those organisations (such as Hereford Hospital and Birmingham Children’s Hospital) where all staff are given the opportunity to participate in activities. This is done through open advertisement, a written application and a panel selection process. This removes any perception that this is an exclusive activity confined to one staff cadre or specialty. It was suggested that community links (such as PONT) have an added benefit by being multi sectoral. Thus meetings and visits involving people from different sectors increased cross sectoral working in the home context.

**Global health surely involves governments and institutions, but fundamentally it is about people — people working together to improve the human condition.
William Roper CEO North Carolina Healthcare System, USA**

20. DONATIONS AND EQUIPMENT

Many of the links have been involved in the supply of furniture, equipment and consumables. It is evident from discussions with southern partners, development agencies and Ministries of Health that this is widespread across all countries, involving institutions and individual and organisational donors from many countries. There is absolute unanimity from southern partners about what makes for good and bad practice.

- The need for the item should be identified by the southern partner (pull) not by the wish of the northern partner to raise money or send goods(push).
- The southern partner should know in advance exactly what is being sent, the condition it is in, whether it is subject to an expiry date and ideally should receive a detailed specification and photograph of larger items (as practiced by the Kilimanjaro/ Northumbria link).
- No expired (or near expired)consumables should be donated (see WHO guidelines).

- Text books should be in line with the southern curriculum and local policies and should be current.
- Providing access to journals may be more useful than sending text books.
- IT equipment should only be sent if the infrastructure and expertise is available and if ongoing costs can be met.
- The southern partner must be able to refuse any items prior to it being shipped.
- Large technical items should only be given if there is the infrastructure to support them (staff, revenue consequences, maintenance capacity, appropriate services such as electricity).
- In general it is better to raise money for bulky low cost items which can be obtained locally, than to ship them from the UK. This is particularly true for items of furniture which can be made locally which, in turn, aids the local economy.
- Any donation needs to take into account the costs of clearing goods through customs and also paying tax on new goods on entry. Unless the southern partner has confirmed they are able to bear these costs, goods should not be sent, as the partner may be liable also for storage costs before goods are cleared.

Whilst not referring specifically to UK partners, almost every partner and ministry referred to the feeling that some goods were being “dumped” (sic) with the motivation being the donors wish to feel munificent, not the need of the recipient. Some southern partners have containers full of unwanted supplies which they cannot dispose of.

It is recommended that a code of conduct for donations be drawn up and incorporated in country MOUs and individual north south partnership agreements.

“In France they refer to “un cadeau empoisonnee” and that is what these feel like”.

“Africans are really polite people, we don’t like to reject but we need to be bold and say no”.

Southern Partners

In the UK there are strict NHS regulations concerning decontamination certification, compliance with Waste Electrical and Electronic Equipment Regulations (WEEE) and particularly destruction of any identifiable information which may be held on computers. This should mean that donors are providing decontamination certificates as well as user manuals, service records, training requirements and liability waivers. No evidence of compliance with the totality of these requirements was found although some UK partners were requiring liability waivers from their southern partners. **These requirements should also be incorporated in the MOU.**

21. NON HEALTH BENEFITS

As a result of the contacts made through health institution links, a number of UK partners have become involved in fund raising or service giving. This may not form part of the

formal link but has arisen because staff visiting their southern partner have become aware of other initiatives and have individually or collectively got involved. This does not utilise any formal funding mechanisms nor is it part of any contract or business plan. However by participating in the link, visitors have identified a cause they wish to support.

Mdawi Orphan Careline Foundation and Women's Training Projects

These small scale charitable initiatives are led by a former employee at Kilimanjaro Christian Medical Centre. They involve the provision of foster care, residential care and schooling for orphans as well as paying for treatment for those who are HIV positive. A training facility has been created including tailoring, carpentry and computer workshops. Significant financial contributions have been received from individuals and groups from Northumbria Healthcare who currently support 30 orphans and a group of young volunteers visited to undertake building and training projects.

Whilst there is considerable cynicism amongst southern partners at all levels about the practice of some northern partners (not necessarily from the UK) to make visits in conjunction with holidays, there is also recognition that this may bring benefit to the economy and may encourage family and friends to visit. Given that a link visit may involve local transport and accommodation, the sums involved may be significant within a small community.

The added value of links should be recognised in terms of both additional charitable activities but also contribution to local economies.

22. CHOOSING APPROPRIATE LINK PARTNERS; WHICH INSTITUTIONS HAVE MOST TO OFFER?

A high proportion of UK link partners were hospitals with fewer institutions delivering primary healthcare. This partially reflects the structure of the NHS where PCT provider arms seem less likely to engage in these activities (perhaps because many PCTs have recently been reconfigured) and primary care practices are independent contractors who may not feel able to fund the inevitable costs in terms of staff time. Yet, in the three countries studied (and in the majority of developing health sectors) the top priority is to strengthen primary (District based) health care.

The links studied included three which involved support to primary care; The PONT/ Mbale link, the Sheffield/ Ataturk link and the Scottish and Malawi clinics project. There was a wide variation in the support provided, which includes: training for community health workers to provide maternal and child health outreach; plans to improve infrastructure; establishing electronic links between health clinics and UK partners, and the development of electronic records. Even given a focus on primary care this raises real issues around the very different context and case mix. There is risk that this can result in inappropriate interventions more suited to the UK than to an African District clinic.

Although hospital to hospital links may be very productive it is clear from the strategic planning documents that they are unlikely to be the highest national or regional priority. Even though the institutional context may be similar, the case mix, agreed clinical protocols and practices, agreed drug lists etc will be very different. There is a real danger that development of new services and techniques at secondary and tertiary level may divert resources (people/ finance) from agreed higher priorities in primary care.

It is strongly recommended that future links should be initiated by southern partners and that they should have the opportunity to “interview” potential partners to make sure that they meet their needs.

There is a strong argument which was put forward by several southern partners and MOHs that suggests that links at all levels may be most valuable on a south to south basis. These benefit from a common experience of delivering a service in a resource-poor environment in facilities which lack basic infrastructure. Good practice is more easily transferable and the “stories” which assist lesson learning are more easily understood.

Comprehensive Community Based Rehabilitation in Tanzania

CCBRT is an NGO which provides services in disability medicine, HIV Aids and rehabilitation. Although CCBRT has a link with Moorfields hospital, which provides valuable telemedicine support advising on complex ophthalmic cases, the CEO identified that the most valuable links they have experienced have been with institutions in Nepal, Nigeria and Rwanda. Exchange visits with a focus on community participation, health systems and performance management/ financing respectively have resulted in measurable improvements in productivity and engagement. This was ascribed to similar contexts which aided the transfer of knowledge, skills, attitudes and systems.

23. SELECTION OF LINK ACTIVITIES

The majority of the links examined were primarily undertaking clinical or technical initiatives. This may partially have been governed by the selection method for evaluation. However many were doing additional clinical interventions over and above maternal and child health work. A much smaller number concentrated on non clinical capacity building although Oxford Radcliffe had input on nurse management and Muheza/ Hereford and UCHL/Mulago had undertaken exchanges focussed on building and maintenance. In 2006, the Sheffield group, linked with Atatur hospital, Uganda, had identified major refurbishment of the hospital as a priority; a UK civil engineer had subsequently prepared a project proposal (a community-based initiative is also at the planning stage).

The Tanzania MoH, Director of Hospitals expressed the view that links which focussed on management development would be most appropriate. This view was confirmed by the CEO of CCBRT who felt that development and mentoring in health systems and management issues was particularly valuable. Likewise the Director of Clinical Services, MOH Uganda expressed similar sentiments. The Director of Medicine at Mulago/ Makerere put a strong case that that there was no lack of clinical knowledge (what to do) but the need was for management training and systems (how to do it) Given widespread

support from many of the southern partners visited **it is recommended that northern partners consider making support in management and system development available if southern partners feel it is helpful and appropriate.**

Not all links have an agreed workplan or programme of work (only seven of the focal group studied) and, even where one exists or is being prepared, it is not necessarily the product of joint agreement (one link stated in their response, "Business plan being produced (by northern partners)...no input (from southern partners)". The same link indicated that their methodology for identifying training needs was "What the (northern partners) feel is appropriate" despite a statement that the northern partners had little or no experience in a developing country setting.

A workplan seems necessary to provide clarity of expectations and many links mutually agree a workplan or business plan and take joint responsibility for ensuring it is delivered. This forms part of an "adult / adult" relationship between equals who have different things to offer and who both benefit in ways which "feel fair". In addition this can then be reflected in Hospital or District annual plans (known as District Implementation Plans (DIP) in Malawi. This was felt to be essential by all of the ministries of health visited as it ensured oversight and avoided duplication. As one southern partner explained, the process also provides official "permission" for the work of the link to proceed and removes the need for multiple courtesy visits to the MOH.

Where a major infrastructure project forms part of the partnership plan it may be necessary to also discuss this with the part of the MOH who has a responsibility for capital planning. The evaluation team were concerned that some capital building or equipping projects being proposed (largely by the northern partners) were unrealistic. This creates false expectations.

There are also examples of good practice where the northern partner is buying in to part of a wider plan of development for the institution either by providing training, expertise or by financing a local provider to support the plan (PONT – Mbale CAP), It does however seem essential that transaction costs at the start of a partnership are kept to a minimum and an early focus is identified. This may change over time recognising that a long term partnership is an iterative process.

One northern partner had made four visits with a total of twenty four staff from different specialties and professions travelling to the country concerned. They had spent a lot of time meeting with staff and visiting wards and departments but, despite developing several potential areas of work, still had not reached agreement on the most profitable way to use a partnership. They expressed a sincere belief that it was important to develop friendship and trust first on which to build future work.

A meeting with a senior clinical manager in the southern institution suggested that they saw the progress to date very differently. When asked by the evaluation team what they wanted from the link, they were able to express very clearly the focussed area of work which would produce most benefit. They felt that so many disparate people visiting had not been helpful and had taken up valuable staff time. It was evident that there was great good will on behalf of both parties but the northern partner had not asked the basic question "How can we best be of help?"

24. INITIATIVES

The links considered in this review fell under two broad headings: capacity building and service delivery. The provision of equipment, and infrastructure development have been discussed in the preceding paragraphs. Each is considered in turn.

24.1. Capacity-building

In-country

- UK health experts
 - Short- or longer-term visits/ placements
 - Teaching and training (clinical or non-clinically based) including training-of-trainers programmes
 - Syllabus development/ Training of trainers (ToT) programmes
- Direct support to national training institutions/ trainers
- Sponsored professional training (doctors, nurses, managers, technicians etc)
- Access to learning materials – internet, journals etc

UK-based

- Study visits
- Clinical attachments
- Mentoring

Capacity-building was the principal focus of almost all the initiatives (see Annex 3). Most involved UK visitors visiting their southern partners to provide training. The majority involved short-term visits, typically one to two weeks. Training methodologies included lectures, seminars, and practical, workplace teaching, either alone, or in combination. In some cases, support was provided on a one-to-one basis, addressing a specific area.

Although the training topics had been agreed with southern partners, a number of issues arose:

- UK lecturers were not always sensitive to the local situation (lack of local resources, for example).
- The content of their teaching was more appropriate to medicine in the UK.
- Not all understood the local context and therefore previous experience of working in Africa was a distinct advantage.

KCMC (Tanzania) now reviews the CV's of the UK lecturers (and, where possible, a selection of CV's) in order to assess their suitability. They also provide feedback after the visit. Subsequent visits on a specific topic area (eg, training in laparoscopic surgery, KCMC) benefited from follow-up by the same UK expert. As described earlier, the majority of the institutional links involved hospitals, rather than clinics or local communities; many of these hospitals had a teaching role.

Overall, however, this form of hospital based training was broadly welcomed but it was preferable if there was continuity over a period of time. Multiple "one off" visits by individuals were not found to be as helpful.

Several links have provided longer-term placements. This involved UK experts working alongside southern colleagues. Their support has involved formal and informal teaching, reviewing clinical practice, curriculum development, and management and system development. However, working in a culturally different environment, understanding locally agreed policies and protocols, meeting new (ie, tropical medicine) clinical challenges, and overcoming language problems has posed difficulties for many UK staff, thereby reducing their effectiveness during the first few months of their placements. Addressing workday management issues was valued (Birmingham Children's hospital nurses' six-month attachment to QECH, Malawi). The long-term clinical attachments in Tuele hospital, Muheza have provided significant benefit.

Many respondents (including several northern links) commented that longer-term attachments by UK experts provided the greatest benefit, impacting both on technical skills development of staff and on the quality, and management of service delivery.

UK support in facilitating and funding local experts in order to provide training (PONT, Mbale,) has been welcomed, and has proved effective. In this case the work was delegated to local NGOs, working closely with the District directors of health and their community worker training teams.

Uganda: Mbale-CAP PHC and PONT/RCT

Support aligned with District (and national policy and strategy) to empower communities through the development of a cadre of community health workers – operational level workers, OPLs and community health promoters, CHPs. Roles include health promotion and prevention, simple treatments at village level, referral to health facilities

- Funded training OPLs and CHPs (by district trainers) through NGOs active in villages
- Procured insecticide-treated nets for under-fives and pregnant women
- Input into training, and ToT syllabuses

Results 2006 -7 in Manafwa district:

- Health facility deliveries increased from 71% to 91%
- Increased attendance at health centres
- Reduction in malaria cases in <5s (and consequent increase in school attendance)
- Immunisation (DTP3) uptake increased to 91%
- OPLs/ CHPs recording morbidity data (but not available during the visit)
- Improved coordination between NGOs and district teams; programme extended and now involves additional NGOs



PONT sponsored Operational Level Health Workers display their certificates

Several links had provided funds to support in-country professional training for health workers.

Tanzania: Muheza – Hereford Educational trust

An educational trust has been established by the link in order to support the professional development of hospital staff.

- Two students are attending medical school
- Student nurse training
- UK study visits for four hospital staff each year
- Skills upgrading for hospital staff members

Many links had arranged UK visits for southern partners' staff. These were generally short-term (up to one month), involving observation (there were no instances whereby southern links staff were able to engage in clinical activities), attending seminars etc. In the main, these were seen as effective; "Seeing how things could be done"; "Making me think about how I could do things differently" were just two comments from interviews. Having experience of visiting the UK raised individuals' profiles amongst their colleagues, thereby facilitating their ability to effect change in their own institutions. Again the difference in context meant that some visits were less beneficial, particularly for less experienced, junior staff.

Improving access to educational materials – text books, journals internet access, teaching aids (eg resuscitation dolls) – was highly valued. However it was essential that any text books sent were up to date and relevant. A number of examples of inappropriate gifting were identified which provided disposal problems for the recipient.

The nature of the links - personal relationships, continuity and ongoing support - has resulted, in several instances, of a mentoring process, whereby problems can be shared, discussed, and solutions developed.

24.2. Service Delivery

What constitutes Service Delivery?

- UK professionals provide clinical services (eg, surgical procedures)
- Link partner facilitates service delivery by southern partner
 - Support for training for health workers using in-country training resources
 - Support to in-country agency to deliver services
 - Health systems development
 - Management training
 - Essential equipment

24.2.1. UK experts providing clinical services directly

In Tuele hospital, Muheza UK doctors had taken up senior positions on a long term basis including the post of medical supervisor (this position is now held by a Tanzanian doctor). These all resulted in improved hospital service delivery, notably in medical, obstetric, laboratory and palliative care services.

Tanzania: Teule Hospital, Muheza and Hereford

A longstanding link, providing in-country support and training as well as annual short-term scholarships for all cadres of Muheza hospital staff.

Results:

- Evidence-based protocols for diabetes and hypertension have been introduced following a UK study visit.
- Educational trust has funded in-country professional training (medicine, nursing, and skills upgrading).

As a consequence of the link:

- Two GPs subsequently worked full-time in Teule hospital for 6 years (service delivery and training).
- Establishment of a Palliative Care Hospice (to be a model for national roll-out).
- UK doctor providing comprehensive obstetric care and training, including IPT PMTCT (district uptake for IPT is 91%).
- UK microbiologist has developed laboratory capacity, including CD4 counts for managing HIV/AIDS patients receiving ARVs. The laboratory is actively involved in multi-centre research projects (malaria, HIV/AIDS).

A UK orthopaedic consultant, who had previously worked in Malawi, was increasing turnover of orthopaedic operations in Lilongwe Central hospital. These services were not, however, provided in isolation; local staff all gained additional knowledge and skills, further improving service delivery. These are just two examples.

Capacity building and service delivery

Malawi: Kamuzu Central Hospital, Lilongwe, and Blackpool

A UK-based orthopaedic surgeon (who had previously worked in the hospital) provides training for orthopaedic clinical officers (COs), as well as providing a specialist service for children with orthopaedic deformities.

- Theoretical and practical (operative training) for COs in managing trauma.
- Orthopaedic surgical theatre sessions.
- Service for children with orthopaedic deformities (conservative and surgical management).
- Providing appropriate specialist orthopaedic equipment.
- UK clinical attachments for two Cos.

Results:

“Everyone in theatre is smiling when S**** comes to the hospital”.

- Major orthopaedic referrals (to the tertiary hospital 350km away) reduced by around three-quarters.
- COs managing more complex fractures and other orthopaedic problems.

Service delivery improvement through indirect links support has proved an important means of support. Utilising local resources to provide training, and to deliver effective clinical services has been successful. In the PONT – Mbale CAP link, PONT recognised that the necessary expertise for training was available; the problem was lack of funding. Similarly, local NGOs were already active in the community. By providing the training funds and contracting the NGOs to supervise the newly-trained community health workers, PONT facilitated an effective intervention. Trauma and orthopaedic service delivery in Lilongwe Central Hospital have improved as a result of the training COs received from the UK orthopaedic surgeon.

UK support to improving service delivery management is recognised as important by southern partners. In-patient nursing care has been improved in QECH, Malawi as a result of the longer-term nursing placements from Birmingham Children’s Hospital; the head of the medical department in Mulago hospital, Uganda, believes improving management is the hospital’s most pressing need as did the MOHs in Uganda and Tanzania.

Effective service delivery is dependent on ensuring adequate supplies of essential commodities and equipment. In the PONT – Mbale CAP initiative, the distribution of (PONT-procured) insecticide-treated bednets to pregnant women and the under-fives by community health workers was instrumental to the success of their programme to reduce the incidence of malaria. Likewise in Queen Elizabeth Hospital, Blantyre, essential drugs and equipment are being made available on the paediatric wards supplementing inadequate local supplies.

Support in service delivery can be both useful in itself but also can be used as a vehicle to impart new clinical competences and to strengthen management skills.

25. ARE THE INTERVENTIONS EVIDENCE-BASED?

The review team did not have the time available to conduct an in-depth study of the training syllabuses or the training modalities used (although PONT Mbale had commissioned a review of the training programme they were supporting). On the assumption that the capacity-building provided by the UK links is based on standard UK clinical procedures it is likely that this will be evidence-based.

Evidence-based clinical protocols for the management of diabetes and hypertension (adapted for the situation in Tanzania) have been introduced in Teule Hospital, Muheza; this is the result of an attachment by a member of the hospital staff to Hereford hospital, their northern partner. The community interventions to address maternal and child health in Mbale, Uganda, include many of the evidence-based interventions described by the Bellagio group (Lancet. 2003, 2005).

26. IMPACT OF THE INITIATIVES

As described above, most initiatives have been directed towards capacity building. The majority have addressed the needs of southern institutions (many of which are involved in training themselves); most (although there are exceptions) can be considered appropriate. Training in paediatrics and improving the inpatient nursing care (QECH, Blantyre – Birmingham Children's hospital) should enhance the capacity of the hospital to improve child health services.

Although a proxy indicator for addressing improving overall child health, the impact of this essentially small-scale initiative is unlikely to be reflected in overall national child health indicators (targeted by MDG 4). KCMC has extended some training (and training-of-trainer) programmes to district hospitals and outlying health facilities; in this case, maternal services are likely to improve. The same argument can be applied to many similar initiatives.

There were few instances that demonstrated impact directly attributable to the interventions. The Ugandan Pont – Mbale CAP which supported the training of community health workers in three districts in Uganda has resulted in an increased uptake of safe delivery, fewer cases of malaria in under-5's, increased coverage of EPI, and an increase in the number of health facility consultations. Exact figures (with the exception of the increase in safe deliveries, and immunisation coverage) were not available; district health teams are currently collating the data (provided by the community health workers).

In Tanzania, post-operative infections have been reduced in KCMC (following a series of in-country and UK based training interventions from Northumbria); exact figures were not available. In the same hospital, careful audit of laparoscopic surgery (cost-effectiveness, infection rates) was ongoing. Tuele Hospital, Muheza, is providing enhanced services (obstetric care, palliative care, attracting research funds). The links orthopaedic trauma training for community officers at Lilongwe Central Hospital, Malawi (box) has resulted in fewer cases of major trauma being referred (350km) to the national trauma centre.

No formal M and E frameworks had been established, or baseline data ascertained. In the case of the Pont-Mbale CAP link, this data was available as it was routinely collected by the district health offices.

The shortage of objective data should be taken in context. Almost all the interventions are small-scale; funding, in terms of supporting interventions that can show true impact is modest. The ethos of the links programme is based upon establishing a long-term relationship, friendship, and providing support based on the needs of the southern partners, and not necessarily focused directly on the MDGs (the PONT-Mbale CAP link is the exception; their express goal was to “address the MDGs and Make Poverty History”). The entire process, therefore, is iterative, rather than determining a research-style intervention from the outset. Southern partners were unanimous that:

- They welcomed the links approach whereby they (the southern partners) were able (in many cases) to drive the support agenda.
- Developing a long-term relationship – on an individual basis – was key to continuity and ensure appropriate ongoing support.
- The relative lack of bureaucracy of the links programme allowed flexible, responsive support from northern partners (in contrast to the more traditional, centrally-funded programmes).
- However two links felt that they had more control with a conventional donor programme, “in a donor programme we can choose what we want, with the link we have to accept and be grateful”.

27. SUSTAINABILITY

Sustainability appeared to be a strength of many of the links mechanisms. Whilst three links were still at an early stage of development, and were not, therefore capable of evaluation in this respect, the established links remained active. One exception was Nkhotaka hospital, Uganda; the northern partner – and the review team – had been unable to make contact. Communication difficulties appeared to be mitigating against the success of this link.

In many cases however, interventions were ongoing, and northern partners were continuing their support. North and South partners appeared equally enthusiastic in maintaining their link; in addition to the obvious advantages for the southern partners, it was clear that the northern partners recognised that they themselves benefited from the link. The focus on capacity-building should ensure sustainability. Similarly, the improvements in service delivery – in almost all cases – result from activities by the southern, and not northern, partners; sustainability should be maintained.

Two links examined had experienced changes in key staff. This meant that institutional memory concerning the original purpose of the link had been lost and it was noticeable that successor did not have the same commitment to the activities identified. **Continuity of personnel does appear to be critical to the sustainability of a link.**

28. MONITORING AND EVALUATION

We were unable to find any evidence of any link initiative which had undertaken a baseline survey against which achievement could be measured. Some partnerships had undertaken evaluations retrospectively but the majority stated they were unable to obtain appropriate information. None mentioned information from national health management information systems. It was encouraging that no links had set up parallel data collection systems which would have involved additional transaction costs.

There was general agreement **that it is important to measure progress towards an agreed workplan. This might involve proxy indicators for capacity building such as number of staff trained. Wherever possible, existing information systems such as the Health Management Information System (HMIS) data sets should be used.**

29. THE ROLE OF FACILITATING BODIES

The evaluation was not designed to undertake an evaluation of the facilitating bodies; the methodology used was specifically targetted to identify what made links work well. Among the links studied, four had received support through THET, two through national assemblies and two through other facilitating bodies. When questioned, the major perceived benefit of these facilitating agencies was financial although the THET guidelines were mentioned by some northern partners. Two northern partners believed that the opportunities provided for networking amongst northern partners were helpful.

Additional areas of support were requested as follow;

1. Professional indemnity insurance guidelines for working overseas
2. General insurance advice for clinicians travelling overseas for work / training
3. Guidelines re- temporary professional registration of visiting clinicians with professional bodies in country so that a record could be kept of the numbers of visiting clinicians from various countries across the world.
4. Guidelines for equipment donations.
5. Guidelines for NHS Trusts on a number of issues:
 - How to justify international humanitarian work to a critical public
 - Who will pay for backfill?
 - What level of activity can be supported?
 - How does international humanitarian work fit with NHS objectives?

THET and other agencies do provide guidelines but it seems that these need further amplification

Very few southern partners outside the Ministries of Health mentioned the involvement of THET and, when questioned, the role of the organisation was not generally known. No southern partners interviewed had made direct contact with THET or other facilitating bodies.

THET has agreed an MOU in Uganda and this is clearly a useful first step to increasing harmonisation and co-ordination. In addition both Uganda has a single point of contact

for THET facilitated links and Malawi has a local co-ordinators. Both of these were senior public sector employees.

One link was currently applying for DELPHE funding and another had received it in the past. There seemed a very long time between submitting the bid and receiving notification of support. However the link which had previously had funding through British Council commented, "They were very strict which was very good. We had to motivate strongly for the grant but they knew each project and knew the local circumstances. We knew the people face to face".

Clearly the support and facilitating role of bodies such as THET and PHI are appreciated but it was clear from our sample that links can be equally successful without facilitation. The main "added value" provided is undoubtedly the provision of financial support.

30. EVALUATION OF SUPPORT MECHANISMS FOR LINKS

In its response to "Global Health Partnerships: The UK contribution to health in developing countries", government accepts that there is a need for independent capacity to initiate, support and develop well performing partnerships to ensure country health policy and strategy is advanced effectively. It agrees with the proposal to establish a "one-stop-shop" acting as an information and knowledge manager for UK and developing country organisations.

The centre would not be involved in project implementation or policy making. DFID has undertaken that it will fund the centre for two years with a possible extension of three years dependent on performance.

Alongside funding the establishment of this international health links centre, government plans to establish a Health Links Scheme with annual funding of £1.25 million over the next comprehensive spending review period.

This section considers possible different models/mechanisms for establishing and operating the new UK International Health Links Centre and for administering the Health Links Scheme. It is envisaged that the centre should be independent of and external to government. Government envisages that the Health Links Scheme will complement existing DelpHE and community-to-community links and that it would work as a challenge fund providing support for establishing, developing and sustaining health links with developing country partners.

30.1. Methodology and Scope of Evaluation of Models for Support

More than 20 different organisations or entities were considered as part of this exercise ranging from charities such as Sister Cities International based in the USA to parastatals such as Belgian Technical Cooperation a State development cooperation agency. They included national and international charities, non-government organisations, parastatals, private companies, government agencies and community groups.

An extensive web-based literature search was conducted, and websites of organisations and agencies either engaged in, or with the capacity to, facilitate links were visited. Information was also gathered through E-mail enquiries and semi-structured telephone interviews. One of the limitations of the exercise was the difficulty in making contact with representatives of southern partners either by E-mail or telephone. Hence most of the information was derived from websites and conversations with those engaged in facilitating the links rather than the southern partners participating in the links.

The exercise was not limited to the health sector to ensure that experiences from other sectors were captured, and that other models of facilitating links informed this review. Furthermore, some of the agencies and consortia facilitating these links may themselves be considered potential candidates for future coordination of UK health links. Furthermore, it has not been assumed that agency or consortium member would necessarily have to be UK based.

The organisations and networks that were initially included in the scope of the review of different models were:

- Development Partnerships in Higher Education (DePHE);
- Belgian Technical Cooperation (BTC);
- United Kingdom One World linking association (UKOWLA);
- International Development Fund;
- Ensemble pour une Solidarité Thérapeutique Hospitalière en Réseau (ESTHER);
- The Scotland Malawi cooperation agreement
- The International Academic Nursing Alliance. (IANA);
- Sister Cities International;
- Civil Society Challenge fund (CSCF);
- The Wales for Africa initiative;
- Tropical Health and Education Trust (THET);
- Building Understanding through International Links for Development (BUILD);
- Global Links Initiative;
- American International Health Alliance (AIHA);
- Aus Health International;
- The Humanitarian Health Fund;
- Global Health through Education Training and Services (GHETS);
- The Network towards Unity for Health (The Network FUTH);
- The DFID/ European Union South Africa twinning initiative; and
- Partnerships in Health Information (PHI).

Brief descriptions of those entities not selected for further review and evaluation are at Annex 5.

30.1.1. Review and evaluation of selected models

The following institutions/models were selected for more detailed consideration on the basis that either they had substantial involvement in links already, or that they demonstrated a potential alternative model:

- DePHE

-
- Belgian Technical Co-operation
 - ESTHER
 - The Scotland Malawi Cooperation Agreement
 - IANA
 - DFID/EU South Africa Twinning Initiative
 - The Humanitarian Health Fund
 - THET
 - AIHA
 - The Wales for Africa Initiative
 - The Network TUFH.

Detailed descriptions of the organizations are attached at Annex 4.

31. ASSESSING THE OPTIONS FOR FUTURE SUPPORT TO LINKS

There are several dimensions that can be considered when looking at the options for a model or mechanism for operating the links Centre and the administration of the new Health Links Fund. Whilst it is clear that any agency or consortium selected will need to be independent of, and external to, government as specified in Government's response to the Crisp report, the question is, will the agency be used to advance government's wider development strategy?

As a potential provider of the Links Centre and the administration of the Health Links Scheme the organization must have the capacity to:

- respond to the priorities of the DFID and DH and manage the resources of the Links Centre and the Health Links Scheme to deliver their strategic objectives effectively;
- deliver these objectives whilst operating independently of government and deliver the highest standards of corporate governance and accountability;
- fulfil the role of the Links Centre set out in the response to the Crisp report and, ideally have the potential to deliver the four additional roles listed in the response; and, ideally
- have the capacity to broaden any health links so they support initiatives or links in other sectors.

Basically the Centre will act as an intermediary between the DFID/DH and the two partners participating in the link. There appear to be three broad types of mechanism. Of the seven models examined that were actively and directly engaged in facilitating links/twinning:

- Three appear to offer a more managed approach seeking to deliver specific strategic objectives – they have, or had, a “job to do”.
- Two were community based but still had clear strategic objectives that advanced wider, national frameworks of development policy.
- Two promoted twinning/links in a more general way with minimum intervention from government.

31.1. “Managing” Models

Models such as the AIHA’s HIV/AIDS Twinning Center and ESTHER are used as a development tool to achieve clear policy objectives in what are regarded as priority areas. The DFID/EU South African Twinning Initiative was also used to deliver a clear policy objective. In some of these cases it is clear that this is very much a supply side model in that the interventions supported may not have been identified by the southern institutions involved.

In each of these models, the firm, agency or consortium concerned is, or was, used by the client to manage the facilitation of the twinning process to deliver policy objectives and priorities.

Thus the French Ministries of Health and Ministry of Foreign Affairs use the ESTHER approach to twinning to advance their policy objectives with regards to HIV/AIDS in selected countries. It has very strong ministerial backing, particularly from the Ministry of Foreign Affairs.

With regards to the AIHA’s HIV/AIDS Twinning Center, the overall client is the US Government (USAID) with funding coming primarily from the PEPFAR. However, in many respects actual clients are the in-country US Government teams that decide local priorities and how their allocation of PEPFAR funding should be utilised. The establishment of the Center was based on a Co-operative Agreement between government and the AIHA rather than a contract for specified services.

Thus the client set the broad parameters of what it required and then through dialogue with key stakeholders, worked out the details of how the Center would operate. From the perspective of the AIHA, this enabled them to develop a model that best met the needs of the US Government whilst devolving considerable power to US Government in country teams.

It is interesting to note that the AIHA regards twinning as an important mechanism for implementing development policy that was been used effectively in developing health systems and for capacity building in countries of the former Soviet Union and is now an important tool in the fight against HIV/AIDS in Sub Saharan Africa and South Asia. The Twinning Center model is very much a managed model of facilitation with clear measurable objectives and assessment of performance by the Twinning Center.

With regards to the DFID/European Union South Africa twinning initiative, the new South African government requested help with health service reform and all the links developed as part of the initiative had that specific purpose, engaging HLSP as agents of the DFID facilitated links that would best deliver that purpose.

It is also worth commenting that this is the model where most of the funding for an initiative comes from the facilitator and thus gives it maximum leverage.

31.2. “Community” Models

The Welsh and Scottish government approaches to facilitating twinning and links are similar inasmuch as they are based on communities and are both set within a clear policy framework developed by their respective governments. The Wales for Africa plays a strong emphasis on community development and the Scotland Malawi Cooperation Agreement is, in effect, a country-to-country twinning arrangement with a strong health component.

Each approach is based on development through a wide range of public, NGO, voluntary body/community networks. This is one of the great strengths of the approach because, through these formal and *ad hoc* meetings and networks, whole communities, or in Scotland's case a whole country, are engaged in the development process.

In addition to providing a clear policy framework for their respective initiatives, the governments of Wales and Scotland provide enabling leadership that encourages community involvement and involvement of all sectors of society including the NHS in their countries.

Although the approach of both countries appears to be fairly incremental and organic, it also seems to be fairly “managed” because of the policy framework of their governments and clear strategic objectives. This also provides the necessary governance framework to ensure organisations are working within clear guidelines. This minimises the risk of them being *ultra vires*.

31.3. “Minimum Intervention” Models (Facilitation and Support)

This model appears to be based on the belief that twinning/links are a “good thing” in the context of the wider development agenda and that government resources should be used to promote them within broad policy guidelines. This model could also be called “demand” led and, as such, can be flexible, enabling links to respond to the priorities of southern partners.

Thus the DelPHE approach provides grants and support to twinning arrangements that can demonstrate a link with achieving one of the millennium development goals and that they are building higher education capacity in the host country. If those boxes can be “ticked” then the British Council, that operates the DelPHE programme on behalf of the DFID, can proceed with the support of a partnership. There is no further policy direction or “steer” from the DFID.

The DelPHE programme was developed specifically to promote links in higher education and was built on a significant record of similar work by the British Council in higher education. There is a contract between the DFID and British Council that governs the relationship and there is a clear framework of reporting and accountability arrangements.

THET is a small independent charity that receives a grant from the DFID's Civil Society Challenge Fund and a grant from DH to promote health links between NHS institutions and comparable entities in developing countries. An independent and distinguished Board of Trustees decides THET's policy, priorities and approach. Basically government supports THET to do its “own thing” rather than, necessarily, to implement DFID or DH policy.

32. FURTHER CONSIDERATIONS

In addition to dealing with the question of whether or not the Centre will be required to “manage” twinning activities and to support wider development strategic objectives, there are other factors that could be considered:

- Does the potential provider need to have specific health experience or could a more generalist agency, consultancy firm or consortium facilitate health links effectively?
- It has been observed through this review, that whilst some partners participating in north-south links are well aware of the health issues many lack country knowledge and an understanding of the strategic context. They are often not aware of the need for harmonisation and may be unaware of complementary initiatives. They have identified that what they value most, apart from grants, is more general development support, logistics and an awareness of the practical realities of working in both developed and less developed countries. It is difficult, if not impossible, for any team based in a northern country to be able to provide the contextual information without country representatives of sufficient seniority.
- Is it desirable for the provider to have its own network of representatives or offices located in “target” countries?
- Will the proposed agency, firm or consortium have the capacity and scale to undertake the management of the Links Centre and manage the Health Links Scheme?
- Is there benefit in having the Centre operated by an entity that is also engaged in other sectors of development activity such as education, civil society development and infrastructure development? The community based Welsh and Scottish approaches offer enormous opportunities for “joined up” twinning and adding value to the overall benefits of the twinning exercise. The AIHA, BTC and the British Council also offers the potential, through their “in country” offices to benefit from cross-sectoral working;
- Will grants/funds from the Health Links Scheme only be channelled through the northern partners as with the DFID Civil Society Challenge Fund or will the fund be accessible to north and southern partners?
- Does Government want the new Links Centre to confine its activities to facilitating the development of North-South links or extend its activities to promoting South-South links?

- How will the Links Centre exert leverage on links where there is unsatisfactory performance? For example where the link results in unproductive transaction costs for southern partners; where there is a lack of financial transparency; where initiatives are not harmonised; or where the interests of the northern partner dominate the link and the south is not able to lead.

33. THE NEW LINKS CENTRE: CONCLUSIONS

The discussion identifies three broad approaches that Government could take with regards to the role of the new Links Centre. It is clear that the new Centre will be “independent and external to government” and it is assumed that in, in acting on behalf of the DFID and DH, it will be held to account through a contract, regular reports and some form of independent audit/evaluation.

The Government does not want the new Link Centre to be involved in the development of policy, its role, amongst others, will be to promote the Framework of principles and practice in relation to twinning and links. However, Government policy with regards to twinning could impact on the model selected for operating its Link Centre.

If Government decides a policy with regards to the development of health links that simply seeks to encourage/promote the development of health links as an inherently “good thing”, then the approach outlined in the response to the Crisp report is functional and appropriate. That is that the “DFID and DH will agree terms of reference and will work with others to agree the structure and relationships between the Links Centre and other stakeholders.”

However, if it is minded to go for a more managed approach then it may wish to consider co-operative approach to developing the structure and *modus operandi* of the Centre such as that adopted by USAID in its development of the AIHA’s HIV/AIDS Twinning Center and, to some extent, the development of the DelPHE programme with the British Council. In this latter case the DFID had a continuing relationship with the Council with regards to development of higher education links and involved them in developing the new model.

If, for example, Government decided that it wanted to prioritise say, maternal and child health, the eradication of certain disease groups, HIV/AIDS or target particular countries (as with the Scotland-Malawi link), then it could invite expressions of interest from potential partners (either a single agency or consortium) to work with the DFID and DH to develop the most effective model.

The more organic, community based approach adopted by Wales and Scotland appears to be successful in terms of their own development strategies. However, some of its success seems to depend on the relatively small scale of the initiatives and the intimate involvement, encouragement and political leadership of the government of each country. The Scottish model is only minimally supporting NHS links however, despite this being a legitimate activity supported by official guidance.

If the approach were translated to a wider UK context it would probably require some regional or possibly Strategic Health Authority focus/leadership. It is unlikely that this

would be feasible given the increasing number of Foundation Trusts who do not have a formal relationship with SHAs and the capacity of SHAs to take on additional roles. A single UK International Links Centre could work with this devolved model (including the Welsh and Scottish initiatives) but it would mean less central co-ordination.

The choice of models for a Links Centre is ultimately between

A managed model with focused initiatives exerting leverage through financial incentives to ensure that activities are harmonized, complementary, in line with good governance, evidence based and cost effective. This is likely to result in less local ownership and less local financial support through fund raising. It may also mean that initiatives are supply side driven.

Or

A facilitation and support model which encourages good practice through guidelines and peer pressure which accepts that there are trade offs between encouraging and supporting enthusiastic (but occasionally less well focused) initiatives which generate additional resources but not having leverage to ensure that the best practice is always followed. This model allows (but does not ensure) demand driven initiatives.

ANNEX 1: BIBLIOGRAPHY

- Black RE et al. Where and why are 10 million children dying every year? *Lancet* 2003, 361: 2226–34;
- Bryce J et al. Reducing child mortality: can public health deliver? *Lancet* 2003, 362: 159–64;
- Campbell OM, Graham WJ. Strategies for reducing maternal mortality: getting on with what works. Campbell OM, Graham WJ. *Lancet* 368: 2006. pp 1284 – 1299
- Crisp N. Global Health Partnerships. Feb 2007
- Datta A, Dimmer K. Making an Impact. A THET Research Report on the Impact of Health Links on the capacity of both UK and developing countries' health institutions. May 2007
- Designing and Managing Partnerships between U.S. And Host-Country Entities. USAID Center for Development, Information and Evaluation. May 2001
- Thematic evaluation of Belgian Development Co-operation in the education sector. Inception Report. Education for Change Ltd January 2007
- Furber A, Johnson P Wright J. Survey of international health links of English NHS Trusts (2005) Department of Health
- Health Links: Approaches to Evaluation. Workshop Report. 23 July 2007 (accessible from www.thet.org.uk/index.php#page/index/reportsandnews.html)
- HMG response to Crisp Report .March 2008
- Jones G et al. How many child deaths can we prevent this year? *Lancet* 2003, 362: 65–71;
- Newborn Health: a key to child survival. Special supplement. *Lancet* March 2005
- Proposal developed by THET for CSCF funding, log-frame and 1st annual report. Republic of Uganda. Ministry of Health. Health Sector Strategic Plan II (2005)
- Ronsmans C, Graham WJ. Maternal mortality: who, when, where and why. Ronsmans C, Graham WJ. *Lancet* 368: 2006 pp 1189 – 1200
- The Bellagio Study Group on Child Survival, Knowledge into action for child survival. *Lancet* 2003,362: 323–27.
- United Republic of Tanzania, Joint Assistance Plan (JAST) (2006)
- United Republic of Tanzania. National Strategy for Growth and Reduction of Policy (NSGRP) (2005)
- United Republic of Tanzania. Second Health Sector Strategic Plan (HssP (July 2003-June 2008)
- Victora CG et al. Applying an equity lens to child health and mortality: more of the same is not enough *Lancet* 2003, 362: 233–41; and
- Wood JB, Hills E, Keto F. Hands across the equator: the Hereford-Muheza link eight years on. *BMJ* April 1994
- Wood JB, Hills EA. Hands across the equator: the Hereford-Muheza link. *BMJ* 1988;297:604-7

ANNEX 2: PERSONS INTERVIEWED

Dr Jocinta Amandua	Commissioner Clinical Services, MOH Kampala
Dr Amone,	Deputy Commissioner Clinical Services, MOH Kampala
Dr Ben Amos,	Teule Hospital, Muheza Tanzania
Ms Trish Araru,	Malawi MOH, SWAP
Ms Juliet Bataringaya,	WHO Uganda
Dr Z Berege,	Director of Hospitals, Ministry of Health Tanzania
Ms Lisa Bird,	Scottish Executive
Professor Cam Bowie,	Malawi Medical College
Prof Robin Broadhead	Malawi Medical College ,
Dr James Bunn	QEMC, Blantyre
Ms Rehema Chande-Mallya,	Acting Director of Library Services,Muhimbili University
Mr Sylvester Chawalla,	Health and Allied Sciences (and deputy)
Practices and Malawian clinics	Communications manager to twinning of Scottish
Mbvuto Charwinga	Orthopaedic Clinical Officer, Lilongwe Central Hospital, Malawi
Fred Chemunko,	Chairman, Mbale-CAP PHC committee, Uganda
Claire Chizazi,	Hospital Secretary, Teule Hospital, Muheza, Tanzania
Dr Karilyn Collins,	Muheza Hospital
Peter Davies	Peter Davies Partnership. Facilitated Wales MDG Civil Society Task Force
Colette Dean	Lead for Africa DelPHE
Mr Marc Denys,	Embassy of Belgium, Kampala, lead for development partner group
Dr Steven Dhikusooka ,	Dental surgeon, Atatur hospital, Uganda
Dr Allan Dowler	Cardiff University
Sister Josephine Ejang	Mulago hospital
Mr Griff Fellows,	Oxford Radcliffe NHS Trust
Dr Mandy Goldstein,	Birmingham Childrens Hospital, NHS Trust
Mr Matt Gordon,	DFID Malawi
Dr Philip Gothard,	UCLH, London
Ms Penny Humphris,	THET
Ms Bethan Johnson,	Welsh assembly
Ms J Kemp,	DFID Malawi
Prof E Kessi	Provost, Kilimanjaro Christian Medical Centre, Tanzania
Pastor Allan Lekke,	Mdawi Orphan Careline Foundation, Moshi Tanzania
Ms Brenda Longstaff,	Northumbria Healthcare NHS foundation Trust
Dr Douglas Lungu	Part time THET co-ordinator, Malawi
Mr Frederick Mahlinga,	Senior hospital administrator, Atatur hospital, Uganda
Mr Robert Mangaga,	UWCM coordinator, Mbale District, Uganda
Prof Harriett Mayanja	Director of Medicine Mulago Hospital, Uganda
Mr Conrad Makumbi ,	Senior nursing officer, Atatur hospital, Uganda
Dr Rajabu,Malahiyo,	Medical Superintendent, Teule Hospital, Muheza, Tanzania
Mr Richard Mangawi,	FNDC coordinator, Mbale district, Uganda
Mr Steve Mannion,	Consultant orthopaedic surgeon, Blackpool NHS Trust

Ms Haisha Mawalla, Dr Maria Musoke, Pastor Apollo Mwenyi , Ms Gemma Neville Ms Mercy Nkhalamba, Mr Paul Nkhomia, Malawian clinics	CCBRT Dar es Salaam Librarian, Makerere University Kampala Mbale PONT coordinator, Uganda Scottish Practices/ Malawian Clinics link Blackpool NHS Trust Ambassador to twinning of Scottish Practices and
Ms Rachel Nakalembe, Ms Jemma Neville Ms Mercy Nkalamba, Mrs Nyirenda Dr Francis Obeyo, Prof R Olomi	Medical Librarian. Makerere University Kampala Scottish coordinator, Scottish and Malawi Clinics project Blackpool/ Lilongwe link Matron QEMC Blantyre District Director of Health Services, Mbale district, Uganda Head, Department of Obstetrics, Kilimanjaro Christian Medical Centre Lead on Oxford Radcliffe link)
Dr Stephen Oumia, Ms Potenza Otiogbe, Dr. Rik Peepercorn,	District Administrator, Chairman Mbale MCAP, Uganda Surrey, Sussex NHS Healthcare Trust First Secretary, Health and HIV Aids, Netherlands, Tanzania. Member of development partners troika CEO Johannesburg Hospital
Sagie Pillay Dr Andrew Purkis, Dr Richard Priestley, Justin Silbaugh, Robert Simon James P. Smith Mr Ephaz Sseseshira, Emma Stanley Dr Mark Swai,	THET Pearl of Africa link Executive director, FNDC, Mbale district, Uganda Secretary General ESTHER Executive Director, American International Health Alliance Public Relations, Uganda Partnerships in Health Information Director of Clinical Services, Kilimanjaro Christian Medical Centre (lead for Northumbria link)
Dr Catherine Taylor, Erwin Telman, Dr Sally Venn	PONT CCBRT, Dar es Salaam Primary Medical Care Advisor, National Public Health Service for Wales
Edith Wakumine, Dr Gideon Wamasebu, Colleen Wainwright.	Executive director, UWCM, Mbale district, Uganda District health officer, Manafwa district, Uganda Social Sector Lead, Irish Aid Tanzania and lead of the development partners troika, United Republic of Tanzania,
Dr John Wood, Mr John Wood Ms Tanya Zebroff,	Secretary to The Link Society, Hereford Education for Change Ltd DFID Tanzania

ANNEX 3: NORTH AND SOUTH LINKS INCLUDED IN THE STUDY

UGANDA

Makere Library/ Surrey and Sussex Healthcare NHS Trust

Background

This link has, over time, been delivered by a number of UK institutions. It originally started in 1994 but Surrey and Sussex have only been involved for the last three years. Funding has been provided through PHI and, until 2005 was sourced through DELPHE.

Activities

The major areas of activity have been

- The creation of a website for the Albert Cook Library.
- Support to the creation of a Uganda Health Literature Database

The website is now in place and the webmaster has received suitable support and training. It was last updated in January 2008. It is not possible to ascertain how many people are accessing the website nor what proportion of these are service delivery staff. The database is currently being proof read at the expense of PHI before being released to the public

PONT/ RCT tLHB Coalition against poverty, CAP, (Pontypridd), and Mbale-CAP Primary Health Committee

Background

The link was established in 2004. The Welsh consortium of health professionals wished to establish a long-term, sustainable community-community link between Wales and Africa to address the MDGs and Make Poverty History. The link resulted from a two-year quest to identify a community that would respond with enthusiasm to such an initiative. This, and earlier exposure to the health situation in Mbale in 2002, led to the link with Mbale, a district in Eastern Uganda (subsequently subdivided into 3 districts – Mbale, Manafwa and Bududa districts)

Meetings and discussions over the succeeding 12 months led to a MoU, outlining the nature of the link, and the principles of working together. All activities would be aligned with District and Ministry policy and strategy. Accordingly, the agreed focus was on community development, principally through training volunteer community health workers. The first step involved the establishment of the Mbale-PONT committee, and the appointment of a local project coordinator. Committee membership included district directors of health services, representation from three NGOs already active in the district at community level, and the project coordinator. A pastor from the First Baptist Church, Mbale, chairs the committee.

Activities

A facilitative approach, working through the three NGOs:

- Initial needs assessment at village level conducted by volunteer health promoters.
- Ongoing support to the district training of a cadre of community health workers tasked with providing health promotion and prevention activities, the provision of first-

line management of disease, and recognition of symptoms and signs requiring referral to a health facility.

- Provision and distribution of insecticide-treated bed nets.
- Purchase of goats to aid community development.
- Limited technical support in training curriculum development.
- Exchange visits to Pontypridd.

Atatur Hospital Support Network Uganda, AHSN and Atatur Designated District Hospital, Kumi district

Background

The link was established in 2006. AHSN is a consortium comprising the Sheffield Medical group (includes general practitioners, a nurse and a hospital specialist), Architects for Aid, Engineers for Overseas Development (both charitable organisations), and Pearl of Africa (Ugandan Church NGO). An introduction from Pearl of Africa led to the link with Atatur hospital, a church-based designated district hospital. The hospital Medical Superintendent and the District Director of health services are the core group members.

The purpose of the link is to support the development of clinical services in Atatur hospital and community development. The activities proposed have been aligned with the District strategic health plan:

- Support to hospital staff through training and supervision through the Sheffield Hospital group and general practice).
- Improving hospital infrastructure, and provision of essential equipment.
- Improving communications – development of broadband internet.
- Needs assessment at community level, and support to training for village health committees.

Activities to date:

- Initial visit to Atatur hospital, with a report on priority needs for the redevelopment of Atatur hospital (2006), and a second visit by an engineer who provided a report detailing an outline plan for redevelopment (2007).
- Visit by the Sheffield medical group who conducted a clinical needs assessment in the hospital and at community level. Development of an outline training syllabus for community health workers is planned.

University College London Hospitals, UCLH, NHS Foundation trust and Mulago Hospital/ Makerere University Medical School, Kampala

Background:

The link was established in 2007, the result of a direct request from THET. In 2004 the director of the Women's Health Institute, UCLH had instigated a programme of clinical research at Mulago/ Makere. An MoU between UCLH and Mulago/ Makere had been signed in 2005. The Trust board has approved the link, which has been approved by the Institute for Global Health at UCLH. A series of exploratory visits – involving several multi-disciplinary teams from UCLH – have already taken place. Three core areas have been identified; clinical; management and services; pathology. Details – including funding mechanisms – are at an early stage of development

Support approaches proposed:

- In-country capacity building through visits from Trust staff

- UK study visits for Mulago/Makere staff.
- Exchange programme for doctors and nurses.
- Infrastructure and equipment.

TANZANIA

Kilimanjaro Christian Medical College (KCMC), Moshi and Northumbria Healthcare Foundation Trust

Background

The link with KCMC, the sole consultant referral centre in northern Tanzania, was first established in 1999, when a consultant physician (who had conducted research with KCMC previously) returned with a multi-disciplinary team from the trust, in order to explore possible training links with KCMC. The link was formally approved by the KCMC board of trustees in 2000; the purpose was “to effect appropriate improvements in health and well being of the communities served by the Kilimanjaro Christian Medical Centre through partnership with Northumbria Healthcare Trust focusing on effective and efficient staff Development”. In the UK, the link is supported by the Charitable Funds committee, a subcommittee of the Northumbria Trust board; in March 2008 the link was accepted as a formal country-to-country institutional link by the board.

KCMC has several international links; programmes and activities are coordinated by the KCMC International Collaboration office coordinator.

Activities:

The first links visit took place in 2001. Support has comprised a combination of in-country training by Trust staff, UK study visits and specific training programmes for KCMC staff, and provision of equipment (agreed, and approved in advance by KCMC hospital board). Four areas were identified during the first visit:

- Tissue viability; this has included the establishment of a maggots farm.
- Physiotherapy: In-country and UK-based training has resulted in the establishment of a school of physiotherapy in KCMC in 1995.
- Occupational therapy: support to the school of occupational therapy: training in research methodology, and support to clinical work in the department. 3 million Tanzanians have a disability.
- Clinical coding: following training and in-country support, KCMC has introduced ICD-10 coding.

Subsequent support – again, identified by KCMC hospital board – now includes:

Obstetric ultrasonography: training for nurses and doctors (2006), and an assessment for the development of outreach obstetric ultrasound services in Hai district

- Theatre nursing/ CSSD: courses for nurses in infection control, decontamination and theatre nursing working in KCMC and in district hospitals in the region.
- Laparoscopic surgery: laparoscopic surgical services have been established at KCMC; ongoing training is provided by the Trust-trained KCMC surgeon.

Additional support activities:

- Mdai Orphan Careline Foundation and Women's Training Projects: led by a former KCMC employee, providing foster care, residential care and schooling for orphans (including paying for treatment for those who are HIV positive). A training facility has been created, Northumbria Healthcare provides significant funding through contributions from groups and individuals.

Kilimanjaro Christian Medical College (KCMC), Moshi and Oxford Radcliffe Hospitals NHS trust

Background:

The link was established in 2001. An Oxford hospital consultant, who had worked at KCMC previously, knew that there was a shortage of trainers, and recognised that a number of Trust staff would be willing to contribute. The executive director of KCMC identified five clinical specialties that would benefit from Oxford Radcliffe's support. The first visit involved an exploratory visit by Trust nursing staff, the start of a relationship that continues to develop over the years. Subsequently, support has extended to additional specialties. There is no formal institutional link; a proposal for a formal twinning arrangement will be made to the Trust board this year. The Oxford Radcliffe Charitable Trust has been one source of funding

Activities:

The principal activities comprise short-term visits to KCMC by Trust staff – nurses and doctors - who provide training through a combination of tutorials, lectures, discussion, and practical training. Selected KCMC staff have visited Oxford for specific training. Equipment has been provided – principally books and teaching aids. In the last 3 years, training (mainly directed to senior staff) has been provided in the following clinical specialties:

- Theatre nursing, Anaesthetics, ITU nursing.
- Paediatrics – ward nursing, medicine, surgery, anaesthetics.
- ENT, oral surgery, dentistry.
- Radiology (including visits to Oxford), radiography.
- Medical physics and medical engineering.

There has been a major focus on paediatric surgery, medicine, nursing and radiology and radiography.

KCMC has several international links; programmes and activities are coordinated by the KCMC International Collaboration office coordinator.

Royal College of Obstetrics and Gynaecology / Muhimbili College of Health and Allied Sciences

Background

The link has been in place since 2005. It has the stated aims to “enhance the skills and knowledge of health information professionals through training, hands-on work and exchanges, to strengthen health information systems and, through this, to improve health and reduce poverty and to ensure that healthcare graduates have skills for lifelong learning”. It was initiated through Partnerships in Health Information who supported the library in developing a website, accessing journals and undertaking exchanges of personnel.

The former college librarian is now employed by the Tanzanian Library Service and there is currently a joint bid with RCOG for DELPHE funding to establish “library corners” in public libraries to provide information on sexual and reproductive health to the general population. This seems to be driven primarily by the Tanzanian Library Service rather than the Muhimbili library.

Activities

- Project board established.
- Visits to Tanzania to develop bid at workshop.
- National librarian visited UK.
- Programme of information skills training has been developed.
- Programme of staff exchanges planned.

Hereford – Muheza Link Society, HMLS, and Hospital Teule, Muheza District

Background:

The link was first established in 1985. Four members of the then Hereford Health Authority, HHA, agreed a link with a developing country would be worthwhile. All had prior experience in Uganda; one member had a high opinion of the (British) Medical Superintendent at Muheza hospital. This resulted in Teule's selection as the preferred link partner, subsequently confirmed after an initial visit to appraise the practicalities. HMLS aimed to link health services in Herefordshire with those in Muheza district. Support would be through exchange visits, teaching in Teule hospital (now a designated district hospital), and the provision of equipment and commodities. HMLS, a registered charity, was formally approved by HHA, and the subsequent Hospital Trust have been patrons.

Activities:

- Study visits to Hereford: each year four hospital staff compete to spend four weeks in Hereford, pursuing training in their chosen area (the selection process involves candidates presenting their proposals, justifying the benefits to Teule hospital when their return).
- Visits to Teule hospital: Trust staff – principally doctors and nurses, as well as PCT staff, GPs, a dentist, and a maintenance expert.
- Provision of selected equipment and commodities.
- Establishment of an education trust which has provided funds for medical school training, nurse training, and for other professionals to upgrade their skills.

Support to Teule hospital attributable to HMLS involvement:

- Two Hereford GPs subsequently worked full-time in Teule hospital for 6 years (one as the medical superintendent).
- Establishment of a Palliative Care Hospice (by one of the Hereford GP staff members) - now an NGO, "Muheza hospital Care".
- UK doctor (supported by a church organization) has provided comprehensive obstetric care and training, including PMTCT (with Muheza hospital Care), for the past 5 years.
- UK microbiologist (again supported by a church organization) has developed laboratory capacity, including CD4 counts for managing HIV/AIDS patients receiving ARVs. The laboratory is actively involved in multi-centre research projects (malaria, HIV/AIDS).

MALAWI

Feet First (Registered Charity, Blackpool) and Kamuzu Central Hospital, Lilongwe, and the Malawi Against Physical Disability, MAP, Unit, Lilongwe

Background

The link was established in 2003, by a consultant orthopaedic surgeon from Blackpool Victoria Hospital. He had worked as an orthopaedic surgeon in Lilongwe from 1999 – 2003, and wished to continue his in-country support on a part-time basis. Feet First, a registered UK charity established by the consultant, provides financial support for his work.

Activities

In-country visits once or twice a year, for between 2 and 6 weeks:

- On-job and theoretical training for orthopaedic clinical officers, COs, (surgical and conservative management of orthopaedic trauma).
- Orthopaedic operating sessions at Lilongwe Central Hospital and two district hospitals.
- Surgical management of paediatric orthopaedic deformities.
- UK study visits for two COs: orthopaedic clinical attachments, and training courses.
- Provision of specialist orthopaedic equipment and consumables.

Birmingham Children's Hospital NHS Trust and Queen Elizabeth Central Hospital paediatric department, Blantyre

Background

The link was established in 2004, following the success of a six-month visit to QECH by two nurses from Birmingham Children's Hospital. Aims, and an outline programme of support were agreed between a senior consultant and nurse from BCH and the clinical staff at QECH at a subsequent visit to Blantyre. The purpose was to provide a long-term, coordinated scheme of education for doctors and nurses, principally delivered in Malawi, but with focused secondments for selected staff in the UK.

Activities 2004 -7

- In country training by BCH staff: two one-week training sessions by four doctors; two further 6-month secondments of a nurse and a midwife (theoretical and practical training); radiologist provided training in paediatric radiology.
- UK- based training: work-based learning for three nurses (three weeks); training for one clinical officer in paediatric radiology.
- Activity plans are developed and agreed each year.

The Twinning of Scottish and Malawi Clinics Project

Background

The link was established in 2006. The initiative came from a Scottish district nurse whilst on a three-year VSO contract teaching Malawian nurses; she involved her own health centre, Westgate Medical Practice (Dundee) in seeking to establish a twin link with a clinic in southern Malawi. With the help of a community worker (now the project coordinator) a clinic was identified. As a result of a subsequent scoping visit to Malawi, a GP (and senior university lecturer) from the practice made a successful application to the Scottish Executive for funding to extend the twinning arrangements to involve 10 Scottish general practices and 10 government health clinics in southern Malawi. The programme he proposed has been approved by the Minister of Health and the relevant district medical officers.

Proposed activities and support

- Computers with internet access for each health centre (already established in four clinics; procurement for the remainder is ongoing) in order to provide email contact with their Scottish twin for clinical case discussion, and access to on-line educational materials. The project will support IT training for clinic staff.
- Provision of essential equipment for each health centre (first specification prepared, and awaiting quotes from a supplier).
- Short-term exchange visits by Scottish GPs and Malawian counterparts.
- Longer-term aims include setting up electronic patient records, accessible to outreach workers via 3G mobile phones.
- Malawian project co-ordinator “Ambassador” and communications manager for the twinning arrangements appointed and already in post.

University Hospitals Coventry and Warwickshire NHS Trust/ St Anne’s and government hospitals Nkhotakota

NB. It was not possible to make contact with senior staff at Nkhotakota and therefore no visit was made. The following information originates purely from the UK partner

Background

This link commenced in 2005 and was the result of a personal contact through the diocese of Birmingham. The initial focus has been on maternal and child health including sepsis, high caesarean section rates, the potential for using new portable ultrasound technology for identification of pregnant women in the rural setting likely to benefit from hospital delivery, HIV and vertical transmission and the educational needs for the paediatric assessment of sick children. The link received a seedcorn grant from THET and has otherwise been supported through fundraising

Activities

- Summer 2006 scoping visit – 3 people, 2 weeks.
- February 2007 – Obstetric placement, 3 weeks, 1 obstetrician, 2 midwives.
- May 2007 – Respiratory and Diagnostic placement, 3 weeks, 1 physician, 1 nurse, 1 radiographer.
- July 2007 – Paediatric placement, 2 weeks, 1 paediatrician (1 week), 1 GP (1 week), 2 SpRs.
- Fundraising for LandRover Ambulance - delivered in July 2007.

ANNEX 4 OVERVIEW OF ORGANISATIONS WHO FACILITATE PARTNERSHIPS OR UNDERTAKE SIMILAR ACTIVITIES

UK Partnership Models

Tropical Health and Education Trust

Established in 1988, THET seeks to improve the basic health services of the poorest countries, building long-term capacity through training and support. It promotes links between UK health institutions and their overseas counterparts, mounts strategic programmes drawing on links in sub-Saharan Africa, and advocates for policies and activities by others that build upon the lessons of THET's work.

The Trust seeks to assist those who are responsible for training healthcare workers in tropical countries to reach their own goals, preparing those who are being trained in the most appropriate and effective way for the tasks that they will be called on to do, relevant to the needs of the local community, not least those who are poor, disabled and suffering from chronic diseases.

It is a relatively small UK based charity (total budget £1.2 million) with a grant of £500K from the DFID's Civil Society Challenge Fund over three years specifically to facilitate institutional links between the UK institutions/ organisations and counterparts in developing countries. As well as this grant, donations from various bodies and fund raising, THET gets support from DH.

THET's grant application for the CSCF explained that, although it was only able to request £500K (the maximum grant) this only represented half of what was required to fund the project. It anticipated that the balance would be found from the DH. Initially this support was forthcoming in the form of a secondment of a senior manager to support the charity and now takes the form of a grant of £130K pa.

As a relatively small although growing charity THET depends on fund raising and grants and its long-term sustainability is always precarious. With a total budget of £1.2 million, DH and DFID contributions account for approximately a third of THET's annual income. It operates independently of both departments retaining its identity and autonomy. It provide a quarterly report to the DFID that shows expenditure against different budget but neither DFID nor DH provides any steer or direction in terms of priorities or strategic objectives. There are no conditions attached to their grants/contributions.

The case that THET made for funding to the CSCF featured a Steering Group for NHS links. In practice this has stopped meeting and on the basis that the THET Board of Trustees has largely taken over that strategic advisory role. According to the Chief Executive, THET has "a very independent minded, strong and effective set of Trustees. They know what they want and if THET were more managed, there could be the potential for conflict between the charity and its main funders." However, he was confident that the mission, values and principles that guide the development of THET would be very unlikely to conflict with the Framework of principles and good practice that would be developed for the Links Centre.

He felt that THET as currently configured, provided a good foundation for the operation of the UK International Health Links Centre and, if they were successful, the new role would not represent significant change. If they also took on the management/administration of the Health Links Scheme this would involve significant scaling up. At present THET administers the small “seed-corn” fund (£14,000 pa) that supports the development of links.

THET’s criteria for supporting a link are the same as for approving a “seed-corn” grant. links/bids have to demonstrate: that they support a partnership with one of the least developed countries where there is a shortage of health workers; that have completed and submitted a links request form (this demonstrates commitment, ownership and a genuine interest); that it has got the right sort of institutional backing; and that the link fits with the overall plans and priorities of the host country.

There is some flexibility with regards to this last criterion, for example, THET has decided to support a link that targets the development of an epilepsy service in Malawi but epilepsy is not a priority area for the Malawian government.

Although THET gets interest to develop links from the north and south, there tend to be more requests from developing countries. Some appear to come “out of the blue” but most originate from countries where THET is already facilitating links or where there has already been some needs assessment. According to THET, they have 30+ expressions of interest on the go at any one time all of which they expect to mature into links. However none of the links evaluated for this study were initiated this way.

The International Director and her Programme Co-ordinators make up THET’s International Development Team. These are not funded either by the DFID or DH monies.

THET tries to encourage a more managed approach from the perspective of the southern country using in country programme co-ordinators. The team plays a key role in supporting the development of links and, with other UK based personnel have developed agreements with various countries. The draft Code of Practice relating to health links agreed between THET and the Ministry of Health of Ghana is an example of how, working in country, THET believes it adds value to the links process. Other agreements, of different forms, have been made with the governments of Malawi and with Somaliland and Ethiopia.

THET also actively helps partners access other sources of funds and with fund raising. This will come in the form of advice, signposting, providing contacts and practical help with putting together cases for funding applications. This was not specifically mentioned in the response to the questionnaires completed by northern partners

Although one respondent to the questionnaire stated that financial support was most important they felt it would be helpful if advice could be easily obtained from a central point and specifically mentioned the new UK Centre for International Links.

If a more managed approach were introduced with specifying priorities for links then there could be a conflict with the THET approach because it believes, very strongly, that

priorities should be set by southern partner. However the Chief Executive is confident that any areas of possible conflict could be worked out through dialogue.

At present the DFID's approach to facilitating north south links is the epitome of a "hands off" non-managed model. There is no attempt to manage the relationship to advance DFID policy or development priorities. The view seems to be that health links are a "good thing" in themselves and that, by making a grant to THET, it can effectively advance the development of links for the benefit of the NHS and southern partners.

Key Issues from THET

- A small active charity with excellent UK connections.
- Increasing in country presence but somewhat "ad hoc".
- Relatively little of DFID and DH funding is actually used to directly fund links.
- Provides guidelines, support and facilitates networking.
- Supports a demand led approach.
- Very little leverage to discourage supply driven approaches by northern partners.

The Scotland Malawi Cooperation Agreement

On November 3, 2005, the then First Minister Jack McConnell and President wa Mutharika of Malawi signed a Co-operation Agreement that outlines key areas in which Scotland and Malawi will work together for their mutual benefit.

This is, in effect, a country-to-country twinning arrangement with the overarching aim to deliver the MDGs. In addition to other areas that might emerge over time, the agreement specifically covers: civil governance and society, sustainable economic development, education and health. The Malawian Ministry of Health believes that this agreement has the potential to ensure that Scottish initiatives are harmonised with both national and local plans.

The aims of the Health Stream are to build workforce capacity and strengthen the health systems, with an operational focus on maternal health services and community health support. Given the nature of the International Development Fund and the nature of the long standing Scottish Malawi the link, has seen a multiplicity of activity being delivered. The majority of the activity does not relate specifically to links involving NHS bodies although such links are specifically encouraged. (through Chief Executive letters) There is some feeling in country that whilst some of these are strategic there are probably too many initiatives and some of them lack focus.

The interventions and initiatives range from major capacity building exercises to some fairly small but active links between, say, schools in Scotland and Malawi. Any Scottish organisations/institutions may bid for grants from the International Development Fund to carry out projects in Malawi that meet with the aims and objectives set out in the Co-operation Agreement. Thus NGOs, NHS bodies, charities and voluntary bodies have all received grants. The Scottish Government (SG) and the Government of Malawi have six monthly Joint Commission reviews to assess progress and discuss priorities for future funding. Current policy on International Development within the SG is under review and announcements are expected shortly on future funding priorities.

Funding for health projects has fallen into three categories: large scale projects that appear to be able to receive a maximum of up to £250K spread over three years; the "Small Grants Scheme that provides "one off" grants of up to £20K; and the Humanitarian Health Fund that provides "one off" grants of up to £5K.

Of the large grants, only one appears to have been targeted on developing a link (£94K for the Scottish Primary Care Group for twinning with health centres in Malawi). Most are concerned with capacity building and supporting the training and development of health workers. Institutions as diverse as Bell College, Tearfund, the Christian Blind Mission, Concern Worldwide and the Dundee School of Medicine, Nursing and Midwifery have all received these large development grants.

Of the small grant scheme grants, one provides £20K to develop links between a High School in Coatbridge and a school in Malawi by promoting a health education programme in both schools. The other grants (of up to £20K) are more concerned with smaller development projects or are being used for enabling work.

The small grants (up to £5K) from the Humanitarian Health Fund provide support for smaller projects. Most are involved with supporting the costs associated with delivering some professional capacity building/training in Malawi. Three of these (out of 25 in 2006/07) small grants were involved with supporting twinning.

There is optimism from Scotland that the local partnerships that have been developed (particularly through NGOs) will continue to grow, and in some recognition in both Malawi and Scotland that they contribute to health outcomes at a local level, especially among the smaller organisations.

The last three years have seen substantial forward movement, not least in building up a strong platform of engagement, and in creating a global awareness within the Scottish population. The huge number of links is evidence of the commitment of Scottish health providers, and the capacity within the population to contribute to a national cause and support a national concern.

The links are felt by the Scottish administration to reflect a growing understanding of the nature of reciprocity within engagement, moving Scottish international activity away from "doing good" to Africa, to a much more globally centered, global influenced thinking which recognises the importance of sharing good health, and protecting against disease, and its contributing factors.

The agreement has been built upon an historical relationship between Scotland and Malawi. This "special" relationship has enabled the people of Scotland to contribute communally to an international agenda and to participate in a national affiliation with a developing country.

Key Issues from the Scottish Malawi Cooperation Agreement

- Based on a formal government to government agreement.
- Commitment to be harmonised with SWAP.
- Concentration on single country with strong historic links.
- Very wide range of activities; links between NHS organisations in the minority.

- NHS bodies specifically empowered to form links.
- Relatively well funded.

Wales for Africa

The First Minister of the Welsh Assembly launched a Draft Welsh International Sustainable Development Framework on 04 October 2006. The Framework recommended that the public sector in Wales should be better supported to create more formal links with counterparts in developing countries that are Millennium Development Goal focused.

The Welsh Assembly Government has committed itself to the delivery of the UN Millennium Development Goals and decided to focus its efforts on Sub Saharan Africa. A Welsh Health Circular: NHS Wales Health Links with Sub-Saharan Africa and other Developing Health Systems published in October 2006 empowered NHS organisations in Wales to demonstrate its commitment to overseas links and its support of the Millennium Development Goals within its stated goals. This provides a much clearer governance framework for partnerships than exists in England

Chief Executives and HR Directors were furthermore asked to amend continuing professional development policies to allow visits, secondments, exchanges and the management of projects to be recognised as one of the options allowed to NHS employees.

Twinning initiatives are a key element of the Welsh Assembly Government's development strategy and are organised under the auspices of the Wales CVA (Council for Voluntary Action). It has a budget from the Welsh Assembly Government. It has established a Wales MDG Civil Society Task Force with membership including civil society groups (Oxfam etc), representative of existing links, Welsh Assembly. Monies were made available to facilitate the development of the group. It now has a full time project manager.

The Welsh Assembly Government (WAG), through the HR Division of NHS Wales makes £50K pa available to support links. The HR Division advertises for those interested in applying for grants once a year. A specially constituted committee considers the applications and makes recommendations to the WAG for approval.

This year (2008) 20 bids for funding were received. Nearly all were asked to make a presentation to the Committee. One benefit of this is that the presentations provide an excellent opportunity for networking and learning from the experiences of others. The grants are, in effect, seed-corn grants to support the development of new links. Ten grants were approved; a typical grant was for £5K. In theory the upper limit is £50K and in the past, grants of up to £18K have been made.

Each case is decided on its merits and the committee tries to be as flexible as possible whilst ensuring that: the link will be of demonstrable benefit to Wales; that it will advance the delivery of some or all of the MDGs; and that the bid has the support of an NHS unit or entity. In reaching its decisions, the committee seeks to achieve fair spread of grants across Wales and across community and hospital based services. Groups of GPs are able to bid.

The successful applicants receive a formal grant offer from the WAG that sets out the conditions of the grant that, in effect, forms a contract. The HR section of NHS Wales monitors performance, however, progress reports are made back to the committee.

The Gold Star Communities programme a pilot scheme to engage communities in community linking in support of the MDGs is also active in Wales. They have criteria for awards and the Gold Star Committee project can make small grants in support of twinning.

The Wales for Africa Health Links Group that places a lot of emphasis on informal networking. It comprises those who are participating in links and those with a stake in the process including THET. It is run by a committee that is encouraged/ supported by the Welsh NHS and the Assembly. It has a small fund of £50K that comes via the Wales for Africa initiative to support links. It aims to promote good practice, sharing good practice, dissemination of good practice, capturing enthusiasm and has run a conference with over 130 people attending representing individuals, established links, “embryonic” links and other stakeholders. It is set to become an annual event. The Group/network is growing as number of links increase. Some limited staffing support is provided for the Group.

There are several examples of very active primary care based links that are seen as part of wider community to community links and these have been encouraged both by the overall policy direction of the Welsh Assembly Government and a strong development networks.

It is important to understand that, in the context of Wales, scale is important, as one respondent put it, Wales is really “only a village” and everyone knows everyone else and the development of links has been very “organic” growing incrementally from community based groups.

Key Issues from Wales

- Coherent framework of policy and strategic objectives decided by and supported by government.
- The network of committees and groups that have been established are perceived to progress that policy.
- Support and encouragement of the Welsh Assembly.
- Grants allocated based on evaluation of proposals.
- Strong monitoring framework.

Development Partnerships in Higher Education

The DFID is investing £15 million over 7 years in DelpHE which, allowing for a start up phase and tapering down towards the end of scheme, means it will be allocating roughly £3 million per year in supporting partnerships with Higher Education Institutions (HEIs).

The overall goal of DelPHE is to enable HEIs to act as catalysts for poverty reduction and sustainable development. DelPHE aims to achieve this by building and strengthening the capacity of HEIs to contribute towards the MDGs and promote science and technology related knowledge and skills. It is anticipated that around 200 partnerships will be funded during the lifetime of the scheme.

HEIs are eligible to apply for funding from any of the DFID's 25 bilateral focus countries in sub Saharan Africa and south Asia. Partnerships may be formed not only with institutions in the UK but also with any HEI from across the globe providing that the lead partner is a HEI from one of the focus countries. Thus South-South as well as North-South partnerships can be developed.

The relationship between the DFID and the British Council grew out of and built on a former Higher Education programme. The Council's UK based office is in Manchester and has four staff. There are also nominated people in each of the Council's country offices that deal with the DelPHE programme. These "in country" staff represent "added value" for the DFID because they are not costed into the management contract.

As managers of the DelPHE programme, the Council: markets and promotes the programme; selects partners; makes grants: bilateral – up to £20K pa for three years; multilateral – up to £50K pa for three years; maintains a panel/network of unpaid, UK based advisors in specialist areas of higher education who comment on bids which must come from the partners (north/south and south/south); maintains a partner database – can facilitate introductions but must be even handed; does an initial sift/shortlist of applications for grants. Any grant must demonstrate a connection with delivering at least one MDG and build capacity in higher education. Where the Council has an in country office the application is assessed locally, on behalf of DFID, to make sure it complies with requirements, undertakes evaluation and monitoring of partnerships and has a role in identifying good practice.

The managers of the DelPHE programme don't regard themselves as higher education specialists, more project management specialists.

Whilst there is a rigorous regime of monitoring and audit, once the partnerships are established, the Council has no particularly active role in managing the link. As long as the grant applications fulfill the criteria of supporting at least one MDG and build HE capacity and "tick all the boxes" in terms of governance, robustness and sustainability, then they tend to manage themselves. It is accepted that a proportion will be completely successful, some will achieve some benefits and some will fail.

Feedback from one of the northern partners observed that the British Council was very active in higher education links. They primarily saw the Council as a source of funding that supported their link through travel grants and enabling contacts. It had found additional sources of funding but didn't find the Council particularly active in supporting the search for other sources. It was observed that the network of in country offices was very important. Where they were good they were an important factor and very helpful. Like all things, quality varied. The view of one respondent was that, without effective in country support, most links would collapse.

One of the key advantages that the British Council could have with regards to facilitating links is that it "represents" a number of sectors in its in-country offices. This has the

potential to facilitate connections, learning and sharing good practice between sectors and thus strengthening links. The view of the UK office is that these connections are best made at the country office level. However, the one northern partner contacted felt that this was something that could be improved. That is, that there was more potential than was being realised. Another respondent for a northern partner was, however, extremely positive about the contribution of the in country offices in this respect. He saw them as critical to the success of the link particularly making links with other projects and initiatives and learning from other sectors. One southern partner interviewed as part of the link evaluation exercise supported this view.

Key issues from DelpHE

- Supports both south / south and north/ south links.
- In country presence for evaluation and management plus potential for facilitating networking and lesson learning.

The DFID/European Union South Africa twinning initiative

This is an example of twinning arrangements facilitated by a consultancy company, HLSP, in the late 1990s. After the development of the new South African constitution, there was a general desire to support the new, democratic country and help with the reform of their health services. Thus the DFID, in conjunction with the EU, agreed, at the request of the South African Government, to facilitate health service reform focused on the development of service level agreements and the introduction of the purchaser provider split. Part of this exercise involved twinning with UK institutions on the basis they were felt to have experience and expertise in this process.

The process undertaken by the consultancy company involved setting out the ground rules for the twinning and selecting the northern partners – 10 Health Authorities and 15 NHS Trusts (not in the same HA area) on the basis of personal contacts and the perception that they were doing a “good” job in terms of the purchaser provider split. HLSP agreed expectations and budgets so there were no misunderstandings about what could be achieved. This was done with the northern partners and the southern partners and the ground rules on accommodation etc were established. No contribution was required from any participating hospitals beyond staff time.

The initiative was initiated in South Africa by the Department of Health, Hospitals cluster and was not led by the participating 10 provincial health departments nor by the tertiary hospitals. Although the southern hospitals participating were initially tertiary hospitals, this was not the case for the UK institutions. In the event this was not material as the focus for the link was purely managerial.

After 10 years, two or three of the links are still in existence; they are not necessarily thriving but they are active. One reason why some twinning arrangements ceased was because of reorganisation/ reconfiguration of the UK twin and personal contacts were lost. A formal evaluation of the initiative suggested that any success of the twinning was based on the fact that there was a clear, short-term objective to support the South African health reform process that was driven by the South African Government.

A senior health manager and current CEO of a major teaching hospital in Johannesburg who was engaged in the twinning process at provincial and national government levels in South Africa takes the view that the twinning process was key to their reform process. His views are generally positive about the outcomes and the facilitation, particularly with regards to increasing skills in the negotiation and management of SLAs but also in relation to increasing management competence more generally. He also suggested that much of the benefit gained from training and development is only really paying off now, 10 years later.

He observed that there were some problems at the South African end, particularly with not meeting deadlines but there were problems regarding the commitment of some of the northern partners. His advice is that more time should have been invested in understanding the needs of both partners and ensuring an alignment of needs. This might have created greater sustainability.

Key Issues from UK/SA twinning

- Initiated by SA Department of Health but not demand driven from provinces and hospitals.
- Fully and equitably funded for north and south twins (but time limited).
- Narrow focus ensured that clear support requirements.
- Many twinning arrangements failed after funding ceased.
- Disrupted by UK health reorganisation.
- Impact felt to be longer term than project duration.

European Partnership Models

The Network Towards Unity For Health

The Network: TUFH encourages partnerships between academic health professions institutions, and with stakeholders, communities, health services, health care providers and their professional organisations. To achieve this it offers its members an annual, international conference on issues that are of current interest. This is held in one of the seven regions of the world and provides opportunities to identify new colleagues for collaborations with like-minded organisations and to strengthen existing links.

The Network TUFH also provides mutual assistance for curriculum reform and, where necessary, can provide consultants. It also provides help and support in identifying other sources of funding for multi-institutional projects. A recent example is the 15 by 2015 campaign (15% of donor vertical funding to primary health care).

The Network: TUFH publishes the peer-reviewed, MEDLINE indexed, unique journal, Education for Health: Change in Learning and Practice (EfH). EfH is an open access e-journal. It also produces a biannual Network: TUFH Newsletter, as well developing and excellent, interactive website.

The Network TUFH has over 235 institutional and individual members worldwide of which about 155 are from developing countries with a Secretariat based in the Netherlands.

From the above description it is clear that the Network TUFH is a valuable resource that can and has been used to support the development of links but that this is not its primary purpose.

Key Issues from Network TUFH

- Not currently engaged in institution to institution links.
- Wide membership.
- Experienced in supporting multiplier funding.

Ensemble pour une Solidarité Thérapeutic Hospitalier En Réseau

ESTHER is an alliance of nine European countries (not the UK), with a secretariat based in France. It is concerned with facilitating twinnings between European institutions and associations and their equivalents in developing countries. It is exclusively concerned with providing professional training and care for people living with HIV and AIDS.

The French founded it and France is by far and away the most active partner in the alliance. It is interesting to note that the current French Minister of Health led the development of ESTHER (and for that matter Médecins Sans Frontières). However Germany is starting to build capacity in this field. Each country organises itself differently. When France takes over the Presidency of the EU in November, one of its aims will be to extend the membership of the ESTHER.

ESTHER in France is an arm's length, parastatal body employing about 30 staff in Paris. It has a budget of 11 million Euros per annum; the main funders being the French Ministry of Health and Ministry of Foreign Affairs. Its activities are complementary to the Global Fund and ESTHER is seen by French Embassies as the one of the main tools for health action in the countries where it operates.

ESTHER works on a three-year contract with its funders. It establishes goals and these are measured using indicators such as the number of people having access to ARVs, and what additional funds have been secured from other sources. It reports every six months.

There is subject to independent, external audit. A detailed evaluation of the work of ESTHER in 10 countries has recently been completed. It is anticipated there will be an English summary. The full report is in French and runs to over 2000 pages.

ESTHER usually has a representative in country to decide priorities, evaluate performance and what needs to be done next in order to support the development of links between institutions. The goal is to strengthen partner countries to better care for HIV/AIDS patients and prevent the spread of HIV/AIDS. ESTHER covers both the health (medical) and social aspects of the challenge.

It develops partnerships between north and southern partners but it is starting to develop south-south links. It is very much a two way process – encouraging visits, exchanges, 'phone, internet etc between the partners.

Before any links can be developed there has to be a formal agreement between the Ministers of Health of both countries. When that is in place, ESTHER receives applications from in country organisations, hospitals and NGOs. Local ESTHER representatives and/or French Embassies help them with their applications. The Board of ESTHER decides which grants should be approved. **The process is demand driven from the southern recipient and the partner institutions are identified through ESTHER.**

A key role of ESTHER is to broker the “marriage” of the two institutions – understand what their main needs are and then find a hospital in France (or in another southern country) that will meet the needs. ESTHER facilitates the signing of agreements and helps to develop project plans for approval.

Funding is provided for training, travel expenses, drugs that are not provided by the local government, equipment especially laboratory equip, conferences. ESTHER also pays some of the expenses of local NGOs and supplements some salaries in the South.

It was observed that, while the French clinicians know a lot about the clinical aspects of what they are trying to achieve, they do not have a knowledge of either the local context nor of development modalities. Thus the emphasis for ESTHER, as with DelpHE with Higher Education, is on development expertise rather than clinical knowledge.

Key Issues from ESTHER

- Expanding to become Europe wide
- As a model for the facilitation of international links, ESTHER has a strong management model with clear strategic objectives and expectations that fit with wider development and foreign policy with regards to HIV/AIDS.
- The process is demand driven from the southern recipient and the partner institutions are identified through ESTHER.
- Based on reimbursement of all costs to northern partner. Therefore strong leverage

An Alternative European Model for facilitation and support to Partnerships

Belgian Technical Co-operation

Belgian Technical Cooperation (BTC) is the Belgian development cooperation agency. As a public service provider, and on behalf of the Federal Public Service of Foreign Affairs, Foreign Trade and Development Cooperation, BTC supports developing countries in their fight against poverty. Thanks to its field expertise, BTC also provides services on behalf of other national and international organisations contributing to sustainable human development.

It is one of four routes by which the Belgian Government channels development monies:

- Through the BTC – they get paid a management fee of all money spent by Government (thought to be 15% of the total allocation). This fee is fixed even where money comes in the form of budget support rather than technical assistance.
- Through two committees representing Universities, therefore education and research (one Flemish and one French) – each receives an annual grant/allocation. This has a health dimension as the Brussels Institute of Tropical Medicine is represented on these Committees.
- Through two Committees (French and Flemish) dealing with technical, vocational and language training similar set-up to the universities committee. These committees do a lot of work in ICT.
- Government also works through NGOs.

BTC is a parastatal, wholly owned by Government. The vast bulk of its income comes from government, they are allowed to take on outside business but this is strictly limited (by fairly recent legislation). It is currently undertaking some micro-credit work on behalf of government but no work on partnerships as in the UK model.

Basically BTC is akin to the British Council's core role before it became independent of Government. However it was suggested that the BTC is far less proactive than the British Council was in generating business. It has the following strengths:

- BTC is a large organisation with a good HQ function.
- Extensive network of in country offices (16 or 18).
- Good administration skills, especially high-level admin skills.
- Experienced in project management.

As with GTZ, there is some question as to whether its status as a wholly owned, parastatal organisation, enables it to comply with EU competition rules. However its local networks could potentially enable it to become a support and facilitating body, not just for UK links, but also for European partnerships.

Key Issues from BTC

- Strong institutional base with in country presence.
- There might be significant advantages in terms of complementarity and transaction costs, in having all European northern partners supported through a single organisation (not necessarily BTC).

MODELS FOR PARTNERSHIP FROM THE US

The International Academic Nursing Alliance

IANA is a US based entity that targets universities that offer a minimum of a Baccalaureate Degree in Nursing to encourage them to exchange information with each other. At present it is still getting its website populated with data from over 100 participating universities. Once that is accomplished, anyone will be able to 'shop' the

site for information at no cost, by simply registering on the site. Faculty and students will then be able to see the entries from universities that are either offering or seeking faculty opportunities for exchanges, sabbaticals, placements, jobs and mentoring.

IANA is also engaged in Student placement opportunities; curriculum development; research and evidence based nursing experiences but, although it may be used to support health links, it is not directly engaged in facilitating north south twinning.

Key Issues from IANA

- This provides a simple web based system for “matching” potential partners.

American International Health Alliance

The AIHA is a tax-exempt non-profit US corporation with an independent Board that, through twinning partnerships and other programmes seeks to advance health in developing countries. AIHA was established in 1992 and seeded by the US Government to develop institution-to-institution twinning programs in Central and Eastern Europe and the former Soviet Union; over 110 twinning partnerships were implemented in Eurasia between 1992 – 2008.

Currently, AIHA's, main project is the HIV/AIDS Twinning Center funded by the US Department of Health and Human Services. The Twinning Center aims to build sustainable capacity to promote HIV/AIDS prevention, treatment, and support in developing countries through volunteer-driven partnerships and is currently managing 32 twinning partnerships in 9 countries of Africa.

The Twinning Centre was established in 2004 for a five-year period. Its grant is renewable for a further five years after 2009 by mutual agreement. AIHA's current budget is \$15 million of which Twinning Centre projects represent almost \$11 million. It is expected that this will rise to between \$13 and \$14 million by 2009.

AIHA currently has a staffing complement of about 60. 25 are based in the Washington DC and approximately another 35 in its overseas offices. Of the 25 in the DC office, 7 are assigned full time to the Twinning Center where they oversee and coordinate program activities. Most of the remaining DC staff are engaged in corporate support functions and supporting their separate Eurasia programme activities. Of the overseas personnel, 12 are engaged with the Twinning Center with offices in Ethiopia, Tanzania and South Africa.

The establishment of the Center was based on a Co-operative Agreement between government and the AIHA rather than a contract for specified services. Thus the client set the broad parameters of what it required and then through dialogue with key stakeholders, worked out the details of how the Centre would operate. From the perspective of the AIHA, this enabled them to develop a model that best met the needs of Government.

Money mostly comes from the US Government via the President's Emergency Plan for AIDS Relief (PEPFAR). As far as the Center is concerned, this does present a problem

because the PEPFAR works on a 9-12 months funding horizon linked to their annual planning cycle whereas most development work, inevitably, is looking for a longer, more strategic horizon. This means that the Center is constantly looking for business.

Although it gets some core funding, the AIHA relies on decisions for funding that are made in USG country offices because all PEPFAR money is allocated at the country level and most funding decisions for the Center are made in country.

The Center funds seed corn grants for preliminary visits then, if the two partners decide to go ahead, they have to produce an agreed work plan of what they're going to do and how they're going to use any monies provided under the auspices of the Center. This is regarded as a very important element of getting commitment of both partners.

The Centre supports North-South and South-South partnerships and a typical grant to support a partnership would be \$200-350 K to enable:

- exchange trips, both ways including travel, per diems, lodging, logistical support and insurance etc.; about 50% of the grant. It was emphasised that two-way visits were very important with the southern partners gaining significantly from visits to the north. They also add value to the northern partner.
- Project support in the field including workshops, training materials, trainee related costs, computer equipment, etc.
- While salaries for the north partner personnel have to be covered by the partner, the Center pays up to 20% of total grant to fund some admin support for the US partner, typically a part time co-ordinator.

Through its own in-country offices and regional field office personnel, The AIHA provide their own logistics, capacity building and sub grant arrangements with the southern partner. The Washington DC Office covers arrangements and support for the northern partners.

The Center acts as a "marriage broker" and helps the partners develop workplans. they feel it is very important to achieve real ownership of the twinning arrangements and getting the leadership of both partners involved. The matching is a competitive process although the Centre frequently solicits interest from prospective partners. A panel makes decisions and the initial awards (for the first visits) are decided through an interactive process.

All subsequent sub grant awards are made in line with agreed work plans. The Center takes a very businesslike approach to twinning, both as a requirement of their governmental funding and remembering that most if not all the northern institutions they are dealing with are well established health sector institutions.

The AIHA sees twinning as no different from any other programmatic approach to development and considers it out performs a consultancy approach. It is very much a managed model of facilitation with clear measurable objectives and assessment of performance by the Twinning Center. Historically, of the 100+ Eurasia twinning partnerships implemented by AIHA, it is estimated that 25% of the twinning links remain intact after AIHA funding concluded. Almost all of the programmatic changes implemented through the programs however have been found to be self-sustaining even

if the links were no longer intact. AIHA assumes that the same experience will hold for the Twinning Center programs.

Although the US Government has funded twinning programs since 1992, it was observed that the US Government has a limited commitment to the twinning process because government bureaucrats like what they know and can manage directly. The twinning process is a catalytic process and is perceived as “warm and fuzzy” therefore many are not particularly interested in it.

In the context of the US health system, these voluntary twinning arrangements are very popular with deans of medical and nursing schools and health system and hospital CEOs. The Center is keen for them to take the credit for the links as it is good for the institution’s marketing and fundraising, raising profile of the institution in a positive way and good for staff development and morale. These are obviously soft benefits that are hard to evaluate.

AIHA’s Eurasia partnerships have been extensively evaluated by USAID. Evaluation of Twinning Center projects is externally funded by HRSA and independent of the centre.

The work on developing partnerships in Europe and Eurasia started well before the development of the HIV/AIDS Twinning Center.

The document “Designing and Managing Partnerships between U.S. And Host-Country Entities” also provides very helpful guidance on the design and management of partnerships.

Key issues from the AIHA

- Strong institutional capacity.
- Twinning has specific focus.
- Well funded partnerships.
- Leverage for delivery in place.

ANNEX 5 ADDITIONAL FACILITATING AND SUPPORT BODIES

These organizations were identified as potential areas for detailed study. After initial investigation through a literature search and some exploratory telephone interviews it was felt that they were less worthy of further study either because of size or because the model of facilitation they used was similar to one already examined. On investigation some were found not to have any major partnership activities.

United Kingdom One World Linking Association (UKOWLA) A charity providing advice, guidance, signposting and support aimed at facilitating a wide range links with developing countries.

International Development Fund. Established and administered by the Scottish Government. It is a Challenge Fund to which organisations based in Scotland bid into to better deliver services with their identified partners in Malawi (and other countries). Its funds are disbursed through three streams; the main scheme, core funding to umbrella NGOs and small grants.

Sister Cities International. A non-profit citizen diplomacy network that creates and strengthens partnerships between U.S. and international communities. It strives to build global cooperation at the municipal level, promote cultural understanding and stimulate economic development.

Civil Society Challenge Fund (CSCF). This is the DFID's main central channel of support for UK based civil society organisations' programmes. Managed in house by the Civil Society Team in the Information and Community Partnerships Department of the DFID.

Building Understanding through International Links for Development (BUILD) A non government organisation that is a coalition of 50+ international agencies aimed at developing positive relationships between a broad range of individuals in the north and south.

Global Links Initiative. A UK based, non-profit organisation that aims to support positive to promote action on social inclusion and citizen empowerment worldwide. It makes extensive use of information technology.

AUS Health International A company providing consultancy services based in New South Wales, aims to promote effective partnerships.

The Humanitarian Health Fund – Established and administered by the Scottish Government it supports the efforts of Scottish-based healthcare professionals undertaking short-term humanitarian work. Grants (max £5000) cover the costs associated with visits to developing countries.

Global Health through Education Training and Services (GHETS) – a non-government organisation based in the US targeting primary care workforce development in developing countries.

Partnerships in Health Information (phi) A UK based charity that promotes and facilitates partnerships between health libraries in the UK and those in developing countries. Phi is a small specialist organisation started in 1992. It is financed by a grant from a Charitable Trust and has one member of staff. Many of the links supported by Phi are based on personal network and professional links. It does not, itself, have funds to make grants. It provides information, guidance and support for the development of links and provides practical help and advice on how to get funding. Phi often directly involved in the partnership. It also facilitates training and exchange of expertise.

ANNEX 6 QUESTIONNAIRE SENT TO UK PARTNERS

Name of UK Institution (Trust/ PCT/ Primary care practice)

Name and address of link partner

Contact person in southern partner organisation and best way to communicate with them (telephone number/ email address etc)

Name and contact details of individual completing this form

History of the link

How long has the link been operational?

What were the reasons for establishing the link?

How was it originally set up (through a personal contact, through community twinning, through THET with seedcorn grant etc)?

What activities have been undertaken in the last three years? (visits (duration), curriculum development, training courses, study visits to UK, equipment donation etc)

If any of this work has particularly related to the health of mothers and/ or children could you please give a detailed description?

Governance

Is the link formally supported by your Chair, CEO and Trust board (for example, has it been agreed and minuted at a board meeting.) If so, when (year)?

Is there a formal, regular (annual?) report to the Trust Board of activities/ benefits/ costs? If not, are there other accountability mechanisms?

Benefit to the Trust

What benefit has the Trust obtained from the link? Can this be quantified or has any assessment been undertaken? (if so, we would be grateful to have sight of this)

Management of the link

Who is responsible for management of the link?

Do they hold the budget/ what is their position in relation to the charity?

Do they undertake this role in work time or in their own? How many hours a month (approximately) does it take?

Funding

Is funding for the link processed through the mechanism of a Charity? If so, who are the Trustees?

If not, are separate accounts held for all income and expenditure relating to the link?

How is the link funded? (fund raising, payroll gifting, grants etc. Please give details).

What is the annual cost of the link to your organisation (if possible split between direct costs (flights, accommodation etc) and management of the link) Please give figures for last three financial years if available.

Staff involvement

Is there an agreed policy outlining whether staff undertake visits in their own time (annual leave) or work time or study leave?

How are staff selected to take part in the link?

Are all staff given the opportunity to apply to take part?

Is travel insurance paid for staff?

How are staff covered for professional indemnity? Has this been formalised?

Identification of Activities under the link

How are activities chosen?

If this involves a needs assessment, who is involved in undertaking this?

What methodology is used?

Does this create a baseline from which you could measure achievement?

Do you agree an annual workplan or a "contract" and, if so, is it costed/ timed and are there agreed measurable monitoring criteria?

Do you have any evaluations you could share with us?

Harmonisation

Is work under the link formally harmonised with national/ regional/ local strategic and operational plans?

How was this achieved and who was involved?

Is it complementary to any other initiatives undertaken by bi-lateral or multilateral donors (e.g. DFID, USAID, WHO, UNICEF)

If so how was this achieved?

Training Activities

Are you involved in training staff in your partner institution?

If so how have the training needs been identified?

Have you developed a curriculum or a competence framework as the basis for training?

If so, is this in line with local or national curricula?

Is it based on agreed local/ national treatment guidelines?

Alternatively, is it based on guidelines issued by WHO or a similar body? (if so, please state which body)

Other activities

Are you involved in direct service delivery (for instance performing operations)?

If so, have you agreed how to achieve sustainability in the long term (funding/ personnel/ equipment etc)?

Support and Facilitation of the link

Was your link supported / facilitated by a third party e.g THET, DELPHE, Scottish or Welsh Assembly etc?

If so, what support have you received from them?

What part of this support has been most helpful?

What support/ facilitation would you like/ have liked if it were available?

Thank you for completing this questionnaire. It will help us identify best practice which should support future link work.