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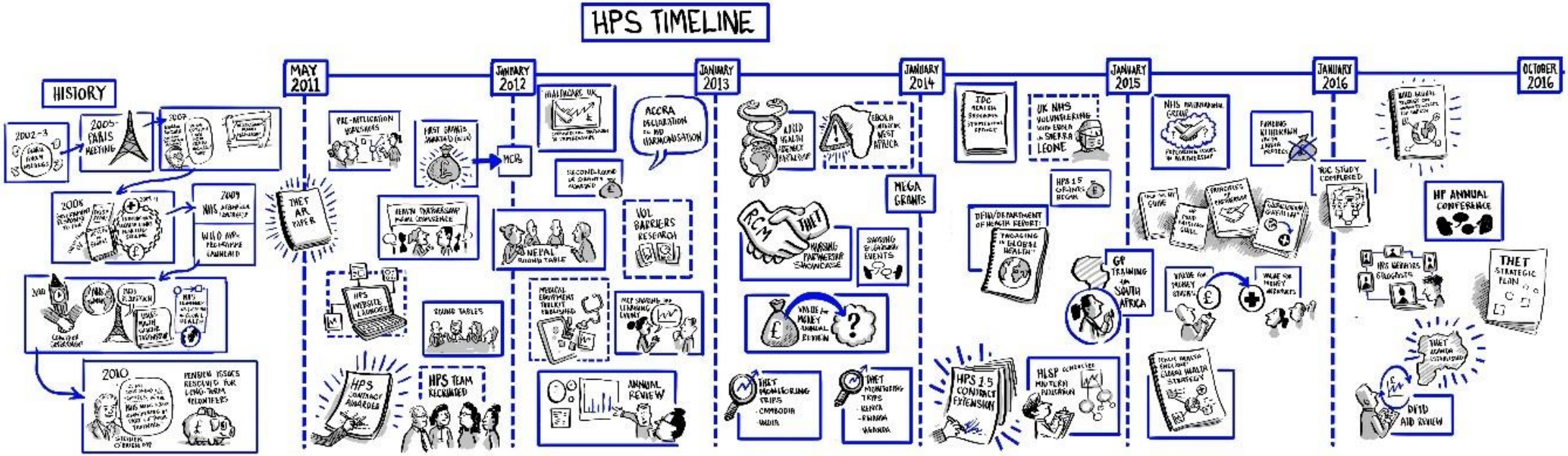
Annex 1: Timeline, Portfolio data and Theory of change

Figure 1: Picture History of the Health Partnership Scheme



The timeline was developed by a live illustrator during the HPS Evaluation Workshop with the Evaluation Reference Group and Wider Stakeholder group on the 11th April . They represent a shared understanding of the evolution of the HPS and contextual factors.

1.1. Portfolio data

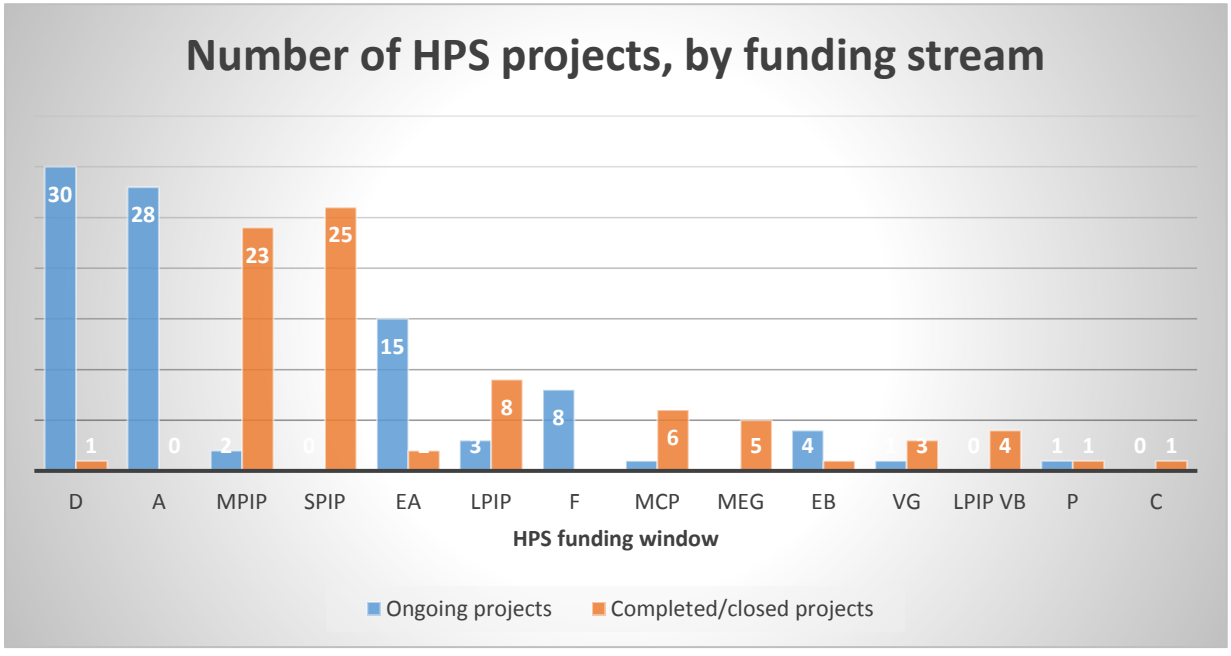
Nearly all partnerships that are funded by the HPS are pre-existing. Some are very early in their development and receive grants for developing partnership activities through visits between partners. Other partnerships are well developed and have on-going activities before they approach the HPS.

Table 1: Number of HPS Grants and Value by Funding Stream

Scheme	ID	Full Name	Total	Ongoing	Completed	Total Value
HPS 1.5	D	Additional support for the HPS Community	31	30	1	£3,420,056
HPS 1.5	A	Additional support to HPS Partnerships to build on and/or replicate successes (invitation only)	28	28	0	£3,782,137
HPS	MPIP	Medium Paired Institutional Partnerships	26	2	23	£649,892
HPS	SPIP	Small Paired Institutional Partnerships	26	0	25	£128,813
HPS 1.5	EA	Support for UK health sector engagement overseas through Health partnerships Strategic engagement with UK institutions on health partnership development	17	15	2	£105,314
HPS	LPIP	Large Paired Institutional Partnerships	12	3	8	£1,933,279
HPS 1.5	F	IPC grants - Infection Prevention Control	8	8	0	£317,498
HPS	MCP	Multi-country partnerships	7	1	6	£6,265,522
HPS	MEG	Medical Equipment Grants	5	0	5	£111,570
HPS 1.5	EB	Strengthening different approaches for health partnership engagement	5	4	1	£573,021
HPS	VG	Long-Term Volunteering Grants	4	1	3	£3,051,227
HPS	LPIP VB	Voluntary bursaries for LPIPs	4	0	4	£59,399
HPS	P	Pilot Grants	2	1	1	£1,358,370
HPS 1.5	C	Knowledge Exchange and Sustainability Grants	1	0	1	£5,150
Total			**176**	**93**	**80**	**£21,761,248**

Note: three projects were suspended

Figure 2: Number of HPS projects, by funding stream



Grants have been used by partnerships in 32 countries the majority in sub-Saharan Africa. 1,700 volunteers

(56% women and 44% men) have worked on these projects and have spent a total of 51,124 days1 overseas. Most of the UK partners and overseas partners have been health education institutions (39% of UK partners in ongoing projects), followed by health delivery institutions (26% of UK partners in ongoing projects) and professional associations (31% of UK partners in ongoing projects). There have been limited research partners in the host countries, though some of the projects do include research. Health projects have mostly been targeted at general health, maternal and newborn health, child health, palliative health and mental health.

Figure 3: Number of HPS projects per country

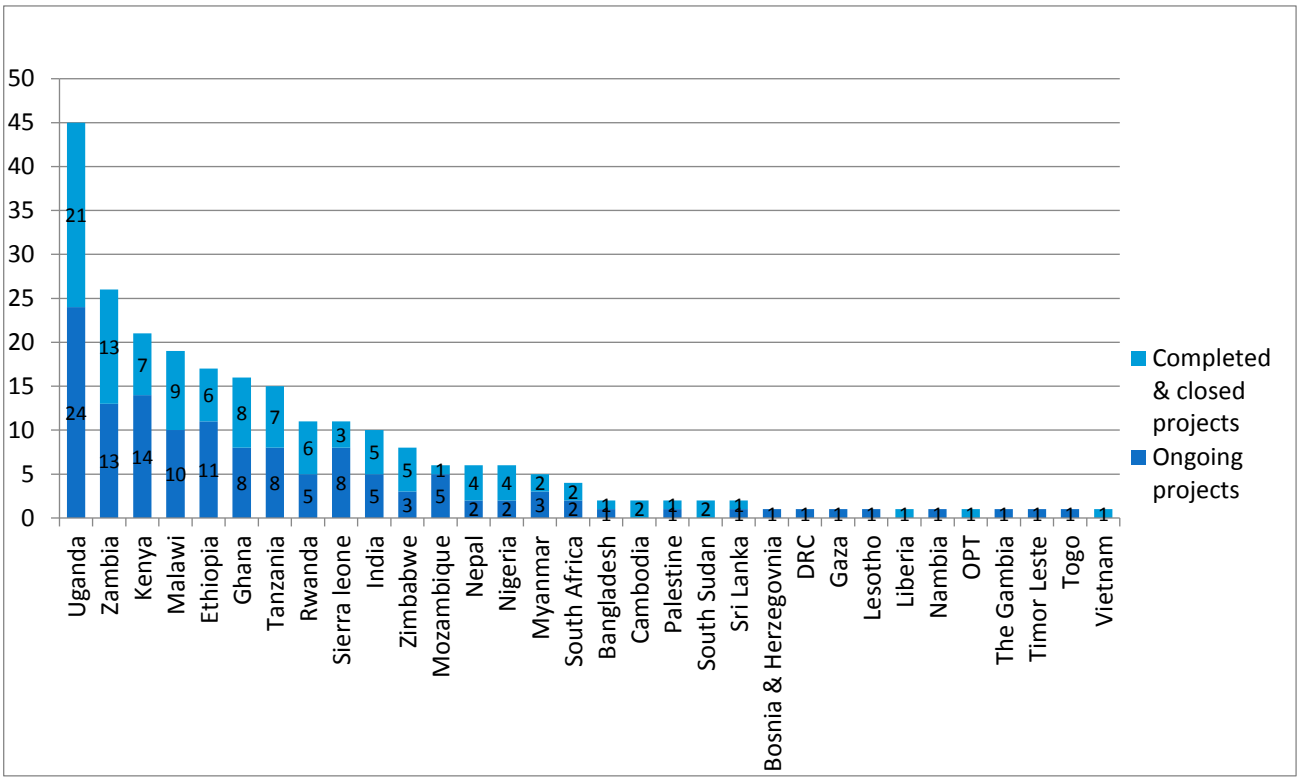
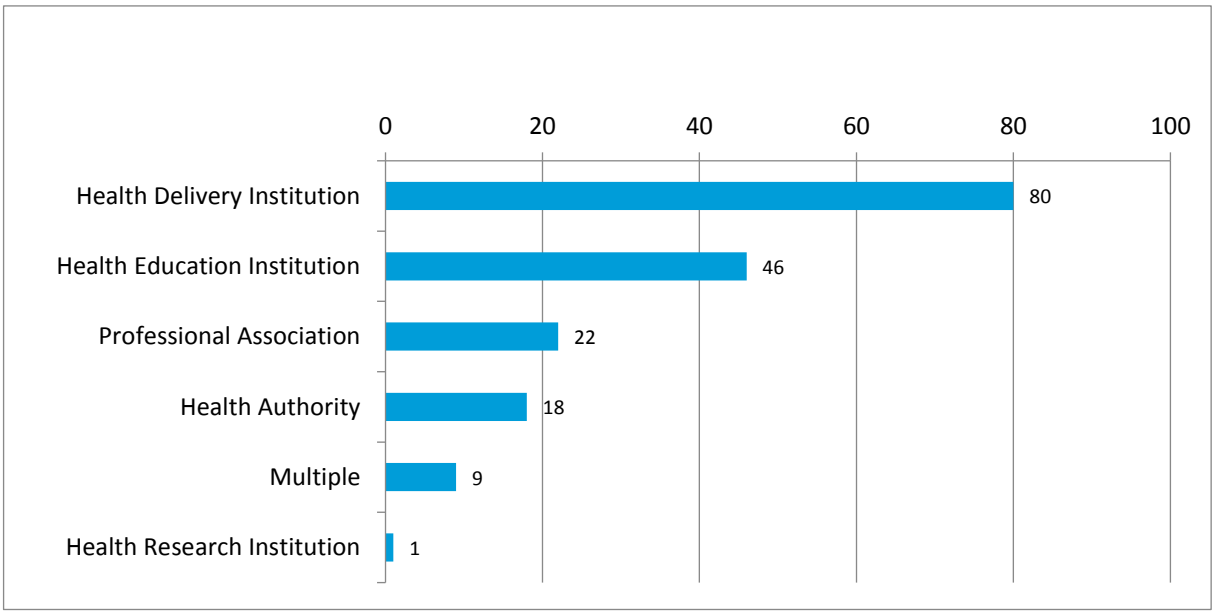


Figure 4: Number of HPS projects by UK partner type (ongoing & completed)



1 Number of volunteer days overseas includes / does not include weekends

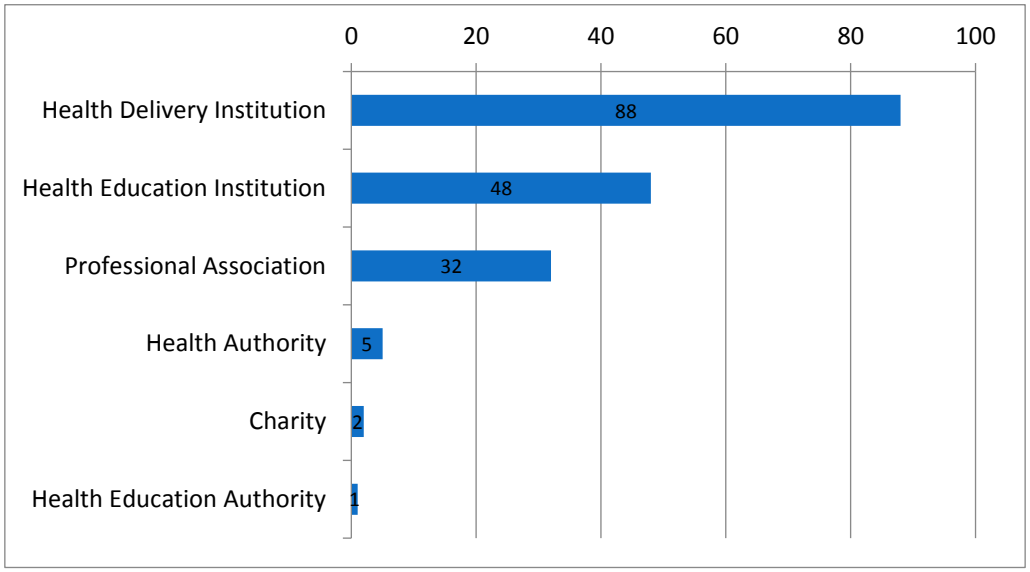


Figure 5: Number of HPS projects by developing country partner type (ongoing & completed)

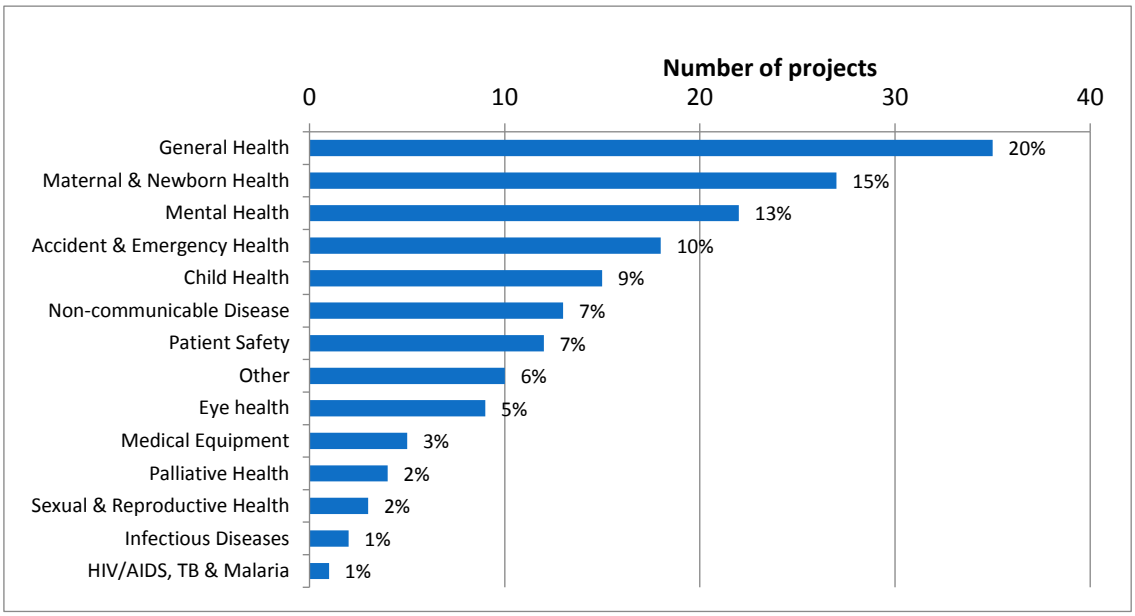


Figure 6: HPS projects by thematic focus (current & completed projects)

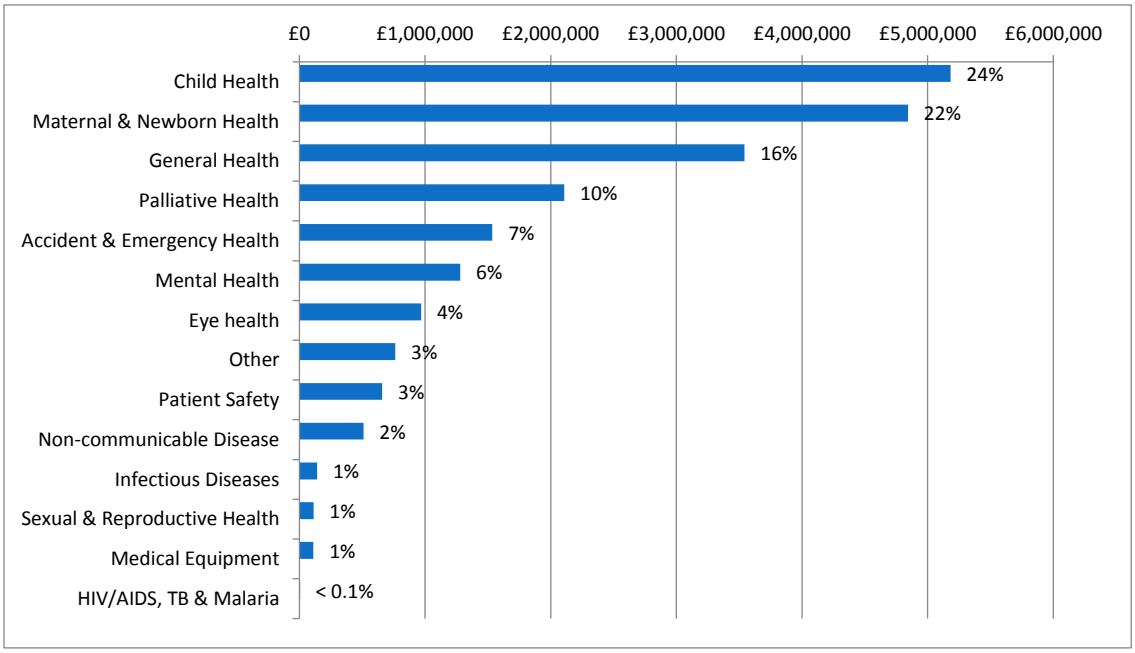


Figure 7: HPS projects: thematic area by funding amount (current & completed projects)

THET has managed the grants with an average overhead of 17%, which has decreased from 18% to 16% since the beginning of the programme in October 2011.

Table 2: HPS Budget and Expenditure

		Direct Programmatic costs	THET costs (fees & expenses)	Total	THET costs as % of total spend
Inception			£142,026	£142,026	
HPS 1	01/10/2011 - 30/06/2014	£10,787,472	£2,290,549	£13,078,021	18%
HPS1 and HPS 1.5	01/07/2014 - 30/03/2016	£7,780,016	£1,529,232	£9,309,248	16%
Total[2]		**£18,567,488**	**£3,819,781**	**£22,387,269**	**17%**

1.2. Theory of change

The Theory of Change (ToC) was developed during the evaluation inception period3 and has again been adapted in light of the experience of the evaluation, in particular the country case studies. During the inception period an evaluation workshop was held with the Reference Group and the Wider Stakeholder Group to work on the different change pathways in the ToC.

The HPS objective is to strengthen health systems, through a strengthened health workforce, in developing countries. Alongside funding the HPS provides a range of networking, technical assistance and communications services to the partnerships, aiming both to improve the effectiveness of the projects and to build and strengthen the partnerships.

The HPS is expected to make change along three change pathways as follows, which are explored in

- Partnerships
- Volunteer and UK health system
- Host country health system

Partnership change pathway

A partnership is generally a long term relationship between one or more institutions with mutual objectives and advantages. While the HPS grants fund projects that the partnerships implement, the partnership relationship is expected to exist and thrive outside of the context of the funding. However funding and joint project implementation is thought to encourage and strengthen partnerships.

Funding opportunities are provided to (i) early stage partnerships as well as (ii) growing and mature partnerships between UK health institutions and health institutions in the host countries. The HPS supports a diverse number of early stage partnerships that have been working on an individual basis as a result of informal and ad hoc connections. These are funded through an open call and the funding or project tends to be directed towards developing personal relationships, visits between partners and individual capacity with the plan that the partnership will undertake a needs assessment and identify or plan for specific volunteering and project opportunities.

Projects from new-ish partnerships tend to be focused on individual and possibly specialist training and learning and less on system wide approaches. As the partnership develops and the institutions implement a project or projects together, learning from the experience usually

Learning from the evaluation: The ***development of a more strategic approach that addressed wider health system constraints depends on better coordination with other HPS / partnerships and with the wider country work on HSS***. Most organisations cannot know about or cover all of the health system constraints that they come across – especially professional associations that usually only work with one cadre. Some UK partners, such as the RCPCH, have a lot of international experience and so more rapidly adopt a strategic approach that enhances alignment with and ownership by the national partner(s) and with government.

2 Not including VAT

3 There was only a very high level theory of change in the original DFID Business Case and THET had done some further work to develop a theory of change by focusing on one project (Edwards 2016). This work was used to think through the initial ToC draft.

leads to identification of a range of health system bottlenecks or barriers that are limiting the effectiveness of their approach. *A more strategic approach that addresses a range of barriers and coordinates with wider government efforts might result from this process.*

(ii) Growing and mature partnerships are funded by the HPS in a more strategic way. These mature partnerships have potential to develop more strategic initiatives themselves as they can respond to a more in-depth analysis of the health system in the host country and tend to be more demand driven. Linkages and partnerships tend to be more institutionalised than just depending on relationships between and through individuals. THET has developed the "Principles of Partnership" based on their experience and learning from managing HPS on what makes a good partnership. They aim to use these to improve the effectiveness of partners' projects and initiatives. The Principles encourage partnerships to be: strategic, harmonised and aligned, effective and sustainable, respectful and reciprocal, organised and accountable, responsible, flexible, resourceful and innovative and committed to joint learning. It is the Principles of Partnership that ensure the programme, and the funded projects, promote and adhere to the Paris Declaration Principles. More mature partnerships tend to have a better understanding of the health system needs in the host country and have a more sophisticated approach to project development and partnership development (possibly described by the HPS partnership principles).

Learning from the evaluation:

While more mature partnerships do tend to have a better understanding of the health system it is not always the case. ***Most of the UK partners are all still quite focused on their area of specialist expertise*** (which is possibly how it should be) and so are not able to develop fully strategic approaches. Nor are they linked with other actors who are working on HSS in order to develop synergies. It is possible that whole hospital approaches are best supported by UK hospital partners or university hospitals. However even those partners are not taking advantage of their whole organisation to integrate a number of inter-dependent system changes within the host hospital. Though there are some examples of where this is beginning to happen – e.g. D2.40 Medical Equipment project Uganda.

All types of HPS Partnerships are expected to develop as a result of interaction with the HPS. Better communications and opportunities for meeting, implementation of a project together and the donation of resources (volunteers, equipment, etc.) develops trust and more enduring relationships - and this in turn is expected to result in more effective projects. Networking and capacity building is designed to build communities of partnerships for sharing lessons and for developing partnerships further. Adherence to the Principles of Partnership leads to better project design, implementation and monitoring. Gender equality and social inclusion improves through partnership interaction and exposure to equal opportunities policies and different social norms of volunteers.

Learning from the evaluation: The ***participation of the host institution depends a lot on their capability to engage***, their institutional strength and their ability to fully communicate the aims of the project and the partnership throughout their organisation. This is particularly important for membership based professional associations.

Volunteer and UK Health system change pathway

Projects funded under the HPS include support from UK volunteers either from or organised by the UK partner institution – which could be a health training institution, a professional association, a health trust (sometimes from a particular hospital or facility with the health trust), a health regulatory body (such as NICE) or a health research organisation. Volunteer contributions can range from short visits and one off training events, to a more long term, institutionalised contribution (with visits of 6 months and over, and ongoing mentoring and institutional support).

THET supports the development of an enabling environment for volunteers by contributing to various international development policy dialogues, by interacting with NHS to improve conditions and through their position as co-chair of the NHS Staff Volunteering Group. All volunteers are supposed to receive volunteer briefing and training from the UK partner. Among other factors successful volunteer placement relies on good planning and understanding of the host institution's requirements and the role that the volunteer will play. It also relies on full participation and presence of the host institution and good communications between the partners.

It is expected that men and women volunteers from the UK will benefit from the volunteering opportunity by gaining important skills, and that this will benefit their own institution in the UK when they return. By the time they return, volunteers will have worked in a low resource setting, contrasting dramatically with the UK NHS, and will be likely to return with a renewed respect for and commitment to the UK health service. Also volunteers' are expected to have improved clinical and leadership skills, increased cross-cultural awareness, new ideas and innovations and be better at team building; they will potentially have increased personal resilience and increased motivation. Men and women from diverse ethnic and religious groups are expected to benefit equally from the volunteering opportunity.

Learning from the evaluation: Evidence of enabling environment for UK volunteers:

The NHS currently pays long term (6 months or more) volunteer pensions while they are away; in some trusts volunteering is included in the staff appraisal process and sometimes volunteering is included as part of professional development (e.g. IGH leadership training scheme Wessex/HEE). Other health workers support volunteers by covering their workload while they are away and supporting their fundraising.

All of these benefits are expected to translate into better quality of care in the UK and a more motivated workforce. Potentially, UK partner institutions could benefit from increased recruitment and improved retention. It is expected that this will benefit HPS and other UK partnerships as the UK health service will be more willing and interested in supporting staff to go overseas as volunteers, and to set up systems and an enabling environment to institutionalise this.

Host country health system change pathway

Health partnerships and the projects they implement under the HPS aim to strengthen the health system in low and middle income countries. Partnership projects nearly always involve some level of human resource capacity building alongside various system inputs, such as equipment and supplies or support with drafting policies and protocols. The projects can focus on individual health facilities or hospitals at various levels of the health system (community, primary, secondary or tertiary); on systems or processes (such as HMIS, referral systems, human resource systems); on regulatory bodies; on health education and training institutions; on research institutions; or a combination of these.

Evidence from the evaluation: In fact there is ***very little evidence that there is any institutional strengthening happening as part of the projects.*** It is all about training individuals – though again there are some examples such as the systems set up in the D2.40, Uganda equipment project and F11 Nigeria IPC project (though it is still very early days).

Learning from the Evaluation: HPS projects tend to be focused at hospital level (either secondary or tertiary), which contrasts with many donor programmes that focus at community and primary health care level. There are very few HPS project activities at primary and community level, though some ad hoc efforts to link hospitals with their communities and to improve referral.

The Partnerships expect to achieve results for both the individuals, the health institutions that they interact with through their HPS project, and ultimately the health system.

Individuals benefit through training and interaction with the volunteers. Pre-service and in- service training and curricula are developed by volunteers and volunteers support and mentor health workers and train trainers. Human resource management and leadership skills might be developed. Sometimes training is certified and institutionalised.

Training curricula and certification, system, leadership and HR management approaches are more likely to lead to sustainable changes in the partnering institution, rather than just the individuals. This will likely effect the health system and will reach more health workers over time.

The volunteer and training approach leads to a range of human resources for health (HRH) benefits including the creation of new health worker cadres, an increase in health workers of specific cadres, improved skills and motivation of health workers. Individual benefits include an increase in technical knowledge and skills, self-confidence, leadership skills. There is also an improvement in health education, potentially reaching a whole cadre or a whole teaching hospital / university.

This leads to a more efficient, motivated and well managed workforce, with better quality assurance mechanisms. This can lead to health cadres with better status and potentially, in turn, to better recruitment, deployment and retention of health workers.

An *improvement of health workforce capability and status should lead to a strengthened health workforce* if the overall management and funding of human resources is improved and if there are specific government strategies to address wider barriers to do with education, recruitment, deployment, retention (such as ensuring health workers will stay in remote areas), that are not addressed, nor can be addressed, by the HPS projects.

Some projects identify and address system constraints during initial assessment and during implementation. By addressing these constraints the projects are able to effect the health system more widely – beyond just the health workforce. Sometimes this happens during implementation and the project adapts to take on wider HSS. This might include better access to and management of medical equipment, better leadership and strategic management skills in health facilities and training institutions, improved research skills, better health financing and improved health management information systems.

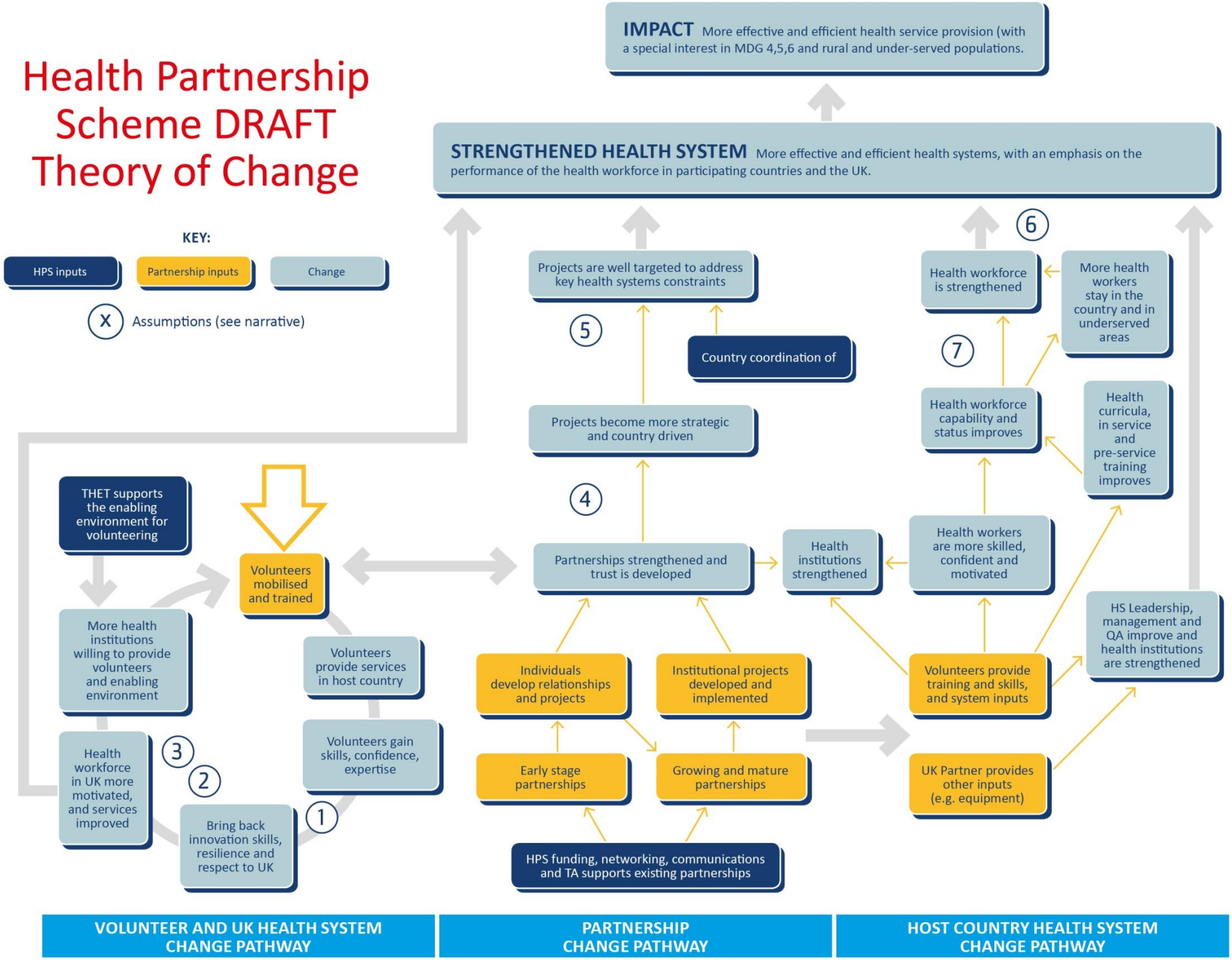
Evidence from HPS funded partnership project with a professional association of anaesthetists in the UK with one in Uganda

Anaesthetists from the UK developed courses that were delivered by Ugandan Anaesthetic Doctors to Anaesthetic Officers to increase access to good quality anaesthetic services in hard to reach areas. The partnership provided the opportunity for Ugandan doctors to develop the professional association, visit international conferences and provide training to neighbouring countries. This has resulted in an increase in status of anaesthetic doctors, which in turn has led to more anaesthetic doctors staying in Uganda and more doctors wanting to become anaesthetists. The training also resulted in doctors having an increased sense of responsibility to perpetuate the training and to improve anaesthetic services in Uganda.

Health workforce strengthening coming from HPS partnerships is expected to lead to more equitable and gender equal human resource management systems and processes, and also increases health worker awareness of gender and social inclusion issues related to service delivery. But there is no specific activity to make sure this is done, so the assumption is a bit unrealistic.

A picture of the **theory of change developed in the inception phase** can be seen on the next page, and can be compared to the updated ToC in the main section of the report.

Health Partnership Scheme DRAFT Theory of Change



1.3. Logframe

Hierarchy	Indicator
Impact	**Impact Indicator 1**
More effective and efficient health service provision (with a special interest in MDG 4,5,6 and rural and under-served populations)	Number of participating institutions demonstrating delivery of higher quality specified health services
	Impact indicator 2
	Number of patients using a new or improved specified health service at participating institutions.
	Impact Indicator 3
	Number of participating institutions demonstrating improved health outcomes for patients
Outcome	**Outcome Indicator 1**
More effective and efficient health systems, with an emphasis on the performance of the health workforce in participating countries and the UK.	Number of developing country health workers demonstrating improved performance, at least 3 months after education or training
	Outcome Indicator 2
	Number of participating institutions demonstrating implementation of improved policies and curricula, 12 months after sign-off or approval
	Outcome Indicator 3
	Number of participating institutions using and maintaining improved equipment, ICT or health information management systems, 12 months after delivery.
	Outcome Indicator 4
	Number of UK volunteers self-reporting or demonstrating improved clinical and leadership skills
Output 1	**Output Indicator 1.1**
Improved and strengthened knowledge and capability in participating health institutions	Number of training course places or other educational opportunities provided to developing country health workers (directly by project or by trainers trained in project)
	Output Indicator 1.2
	Percentage of tested trainees showing improved skills or performance immediately after training or education.
	Output Indicator 1.3
	Number of developing country institutions with improved medical equipment, ICT or health information management systems.
Impact Weighting: 50%	
Output 2	**Output Indicator 2.1**
Improved and strengthened policies, protocols and curricula in participating health and health education institutions or across health systems	Number of national and institutional health strategies and professional standards / protocols to which projects have contributed for development, review or update.
	Output Indicator 2.2
	Number of new or improved policies and professional standards approved and signed off, by end of programme.
	Output Indicator 2.3
	Number of medical education curricula to which projects have explicitly contributed for development, review or update.
	Output Indicator 2.4
	Number of new and or improved medical education curricula explicitly approved for teaching.
IMPACT WEIGHTING: 25%	
Output 3	**Output Indicator 3.1**

Stronger and more institutional and country health partnerships that promote and enable mutual learning and skills and technology transfer	Number of new institutional health partnership Memoranda of Understanding or other formal written commitments.
	Output Indicator 3.2
	Number of institutional health partnerships strengthened.
	Output Indicator 3.3
	Number of UK health professional days spent volunteering overseas + in the UK.
IMPACT WEIGHTING: 15%	
OUTPUT 4	**Output Indicator 4.1**
Effective and efficient grant funding and strategic management support to projects and health partnership community by the managing agent	Amount of grant funding disbursed, within agreed timeframes
	Output Indicator 4.2
	% of timely and appropriate provision of technical assistance to grant holders and other eligible stakeholders, in a 12 month period
	Output Indicator 4.3
	Number of advocacy and communication activities undertaken by THET in support of an enabling NHS environment for overseas volunteering.
	Output Indicator 4.4
	Number of page views for website resource library
IMPACT WEIGHTING: 10%	

Annex 2: Evaluation Questions and assessing effectiveness

The **Evaluation Questions** (EQs) had been adapted moderately from the original questions in the terms of reference and were used to develop the tools for the country visits and other interviews.

1. To what extent and under what circumstances is the HPS programme achieving its stated outcome: "more effective and efficient health systems, with an emphasis on the performance of the health workforce" and is there any evidence of impact? (DAC Criteria: Effectiveness, Impact and Equity)

- To what extent and how have HPS projects contributed to a sustainable improvement in health workforce performance, recruitment, deployment and retention?
- Is there any evidence that this has led to or contributed to improved quality of care and more equitable access to health services?
- To what extent and how have HPS projects contributed to overall system strengthening through strategic planning, leadership, policy and management performance improvements?
- Have HPS projects contributed to more extensive health system improvements, attitude changes and contributed to resilience?
- How has the functioning of the HPS funding mechanism, networking, communications and TA supported effectiveness?
- To what extent have individual projects been effective at achieving their objectives – and what has contributed to this?
- To what extent have gender equality and social inclusion been enhanced within health systems and health service delivery?

2. Is the programme delivering value for money? (DAC Criteria: Effectiveness, Efficiency, Equity, plus VfM criteria of Economy)

- To what extent and how has value been created by the HPS and accrued to volunteers, UK health system and LMIC partner organisations?
- To what extent are the 4Es (economy, efficiency, effectiveness, equity) considered during the different stages in the programme and project cycle.
- How does the cost efficiency and cost effectiveness (of the HPS programme and project approach) compare with other forms of technical assistance?
- How efficiently and effectively is social inclusion, equity and gender equality integrated into programme, partnership and project approaches?
- How can VfM be measured at programme, partnership and project level? (Inception phase question for evaluability)

3. What lessons can be learnt in relation to strengthening partnerships between UK and developing countries' health institutions, the partnership use of volunteers from the UK to deliver projects and the effect of this on project effectiveness (to deliver stronger health systems and build capacity of the workforce)? (DAC Criteria: Relevance, Efficiency and Effectiveness)

- How have the different types of partnership contributed to the effectiveness of projects?
- How well has the programme fostered and supported long term and well-functioning partnerships? To what extent do partnerships adhere to the THET partnership principles?
- How have organisations changed as a result of programme input and the partnerships?
- To what extent is the observed change sustainable?
- To what extent have participating organisations integrated gender equality and social inclusion into organisational systems and human resource management?

4. To what extent have the HPS projects been identified, designed and delivered in response to the host country context and in alignment with government plans and strategies? (DAC Criteria: Relevance and Sustainability)

- What is the quality and extent of the context and needs analysis undertaken for proposal development and during implementation?
- Has a gender equality and social inclusion assessment been undertaken in relation to service users and the health workforce?
- Has the partnership and project responded and adapted to host country and LMIC partner changing situation and needs?
- Have volunteers been able to adapt to and work positively with local conditions, culture and norms in the host country and institution?

5. How has HPS benefited the UK in terms of strengthening the health workforce, health systems and/or in terms of recruitment and retention of health workers? (DAC Criteria: Effectiveness, Sustainability and Equity)

- To what extent and how has HPS efforts to improve the enabling environment for health volunteering been successful at increasing number of volunteers and improving the response to LMIC needs?
- What evidence is there of UK volunteers' increased clinical and leadership skills, increased cross-cultural awareness, new ideas and innovations, improved team building skills, increased personal resilience and increased motivation?
- Have the increased skills and ability of volunteers strengthened their own health institution or resulted in changes to their team?

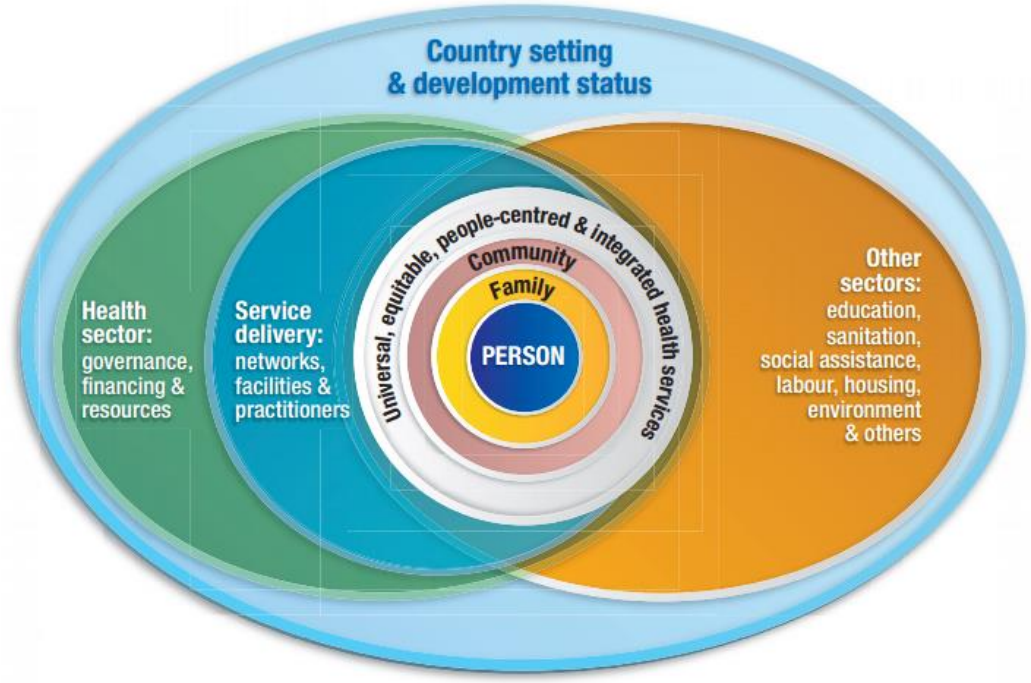
6. How can the HPS (programme, projects and partnerships) be monitored and evaluated?

- Does the M&E system give sufficient information to assess progress against the outcome? What about impact?
- How can potential gaps in information be addressed in the future?
- How effective is the logframe as a tool for monitoring progress towards outcome and impact?
- Are monitoring tools and methods provided by HPS to grantees user friendly and collecting sufficient information?

In order to assess effectiveness the evaluation team used the following concepts for health system strengthening, partnership, and value for money:

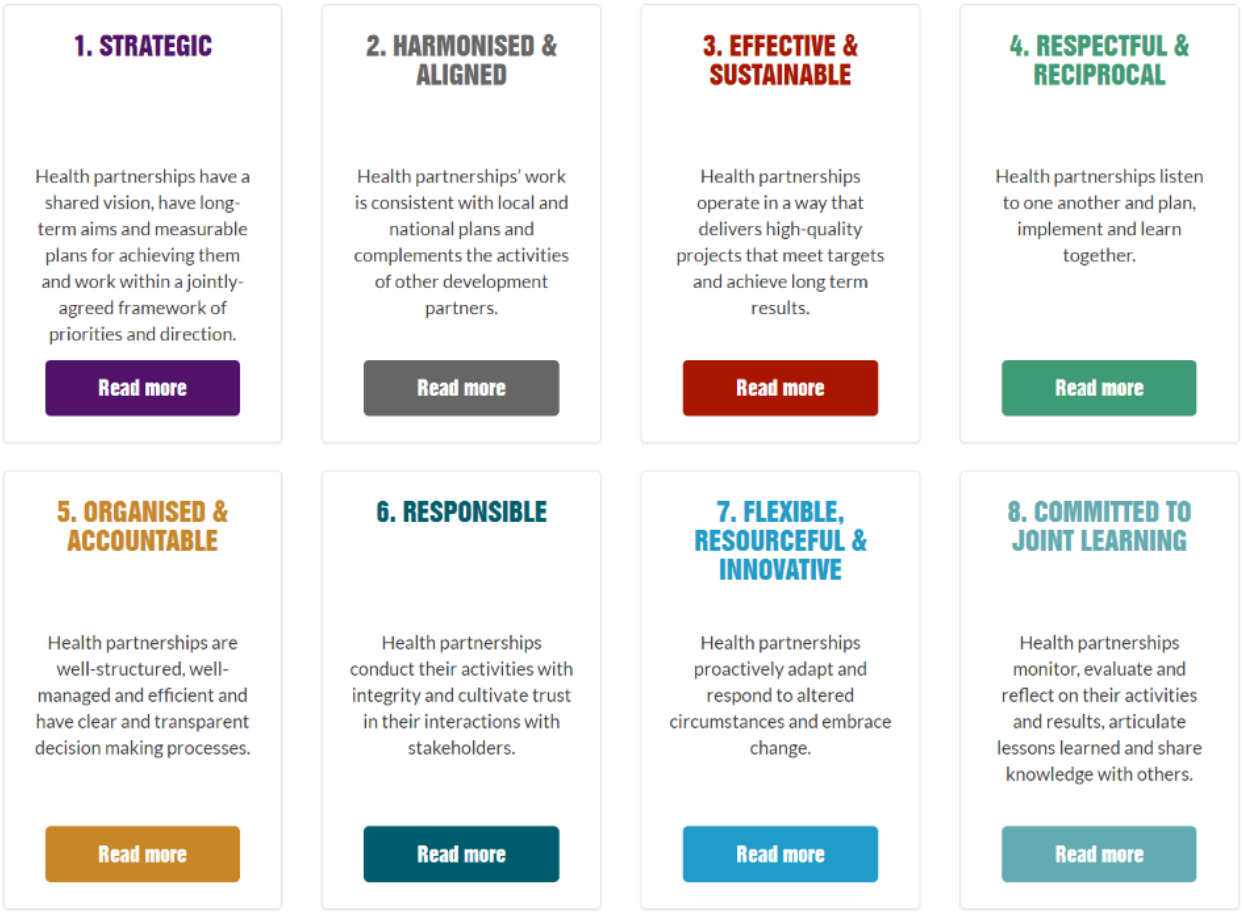
- The understanding and analysis of *health systems* has been undertaken using the WHO Health System Strengthening (HSS) six pillars as a lose framework for checking through HSS issues, with the new "conceptual framework for people centred and integrated health services" also in mind (which was agreed during the implementation period).

Figure 8: Conceptual framework for integrated people-centred health services



- The THET Principles of *Partnership* have been used in order to assess the strength and maturity of partnerships. THET developed these principles in order to support health partnerships to improve the quality and effectiveness of what they do. (The partnership typology that was developed by THET has not been used in the evaluation, nor has it been developed further. This is explained in the main report.)

Figure 9: THET's Principles of Partnership



Source: http://www.thet.org/health-partnership-scheme/resources/principles-of-partnership for further information

- To assess value for money the evaluation looks at economy of the programme in procuring or mobilising the inputs; the efficiency of using the programme inputs to generate outputs; the extent to which the outputs result in the desired programme outcomes (effectiveness); and the extent to which the outcomes generated contribute to increased equity and inclusion of disadvantaged groups. Furthermore, the evaluation looks at the sustainability of the outcomes generated.

Annex 3: Methodology

3.1 Sampling

The evaluation team used a flexible, purposive sampling approach that evolved during the process. It integrates quantitative and qualitative analysis of ongoing projects, various discussions with DFID and THET at different points of the inception phase and discussions with the other key stakeholders during the inception workshop. A purposive sampling method was used to select a sub-group of projects for the country case studies and the remote project studies so that they would be as representative as possible of the different types of project, partners and the geographical regions. The selected projects covered three regions: East, West, Southern Africa and Asia; and a variety of the projects' characteristics (partner type, project technical focus, funding stream, grant size).

Purposive sampling

It was estimated that the evaluation team will be able to look in depth at 2-3 projects per country (total maximum 12 projects), and another 6 projects were to be assessed remotely. In the end 3 projects were visited in there of the countries (Uganda, Sierra Leone and Myanmar) and 2 projects in Zambia. Five remote case studies were conducted. Considering the variety and complexity of the HPS portfolio in terms of types of projects, geographic location, health focus, types of partners, different funding rounds, etc., it was important to make sure that the selected projects are a good representation of that complexity. Ideally, the selected projects should cover the different geographic areas (East, West, Southern Africa, Asia and MENA) and a variety of the projects' characteristics (type of partnerships, project focus, type of grants, etc.). It was therefore decided that the sampling methodology had to follow a purposive approach and that a random selection would not guarantee representativeness of the portfolio.

The selection of projects was made following the decision making process described below and summarised in Figure 3.1 below. We adopted a flexible approach that evolved along the way. It integrates quantitative and qualitative analysis of ongoing projects, various discussions with DFID and THET at different points of the inception phase and discussions with the other key stakeholders during the inception workshop.

1st: Pre-selection of countries with at least 2 ongoing projects

Rationale: to make country visits cost effective by being able to look at a representative range of projects during the visits. The countries were chosen to guarantee this wide range of current projects in all the key criteria identified in order to allow for the right sampling of projects.

Result: 14 countries (with number of ongoing projects into brackets) - Ethiopia (11), Ghana (8), India (5), Kenya (14), Malawi (10), Mozambique (5), Myanmar (3), Nepal (2), Nigeria (2), Rwanda (5), Sierra Leone (8), Tanzania (24), Uganda (24), Zambia (13).

2nd: Data gathering and categorisation for the 14 "pre-selected" countries against the following criteria[4] in order to narrow down to four countries:

a) Country status (i.e. low/ middle income)
b) Geographic location (e.g. East Africa, Central Africa, etc.)
c) Significant support from DFID Country Office (CO)5
d) UK and developing country (DC) type of partner (e.g. health delivery institution, etc.)
e) UK and DC partner sector (e.g. private, public, etc.)
f) Health focus area (e.g. child health, eye health, etc.)
g) Grant size in GBP
h) Project duration
i) Grant type/funding stream (e.g. HPS 1.5 – EA Strategic start-ups, etc.)

4Identification of number of ongoing projects per category (within each category) for each or the 14 countries
5Through conversations with THET it was understood that only projects in Sierra Leone had received significant support from DFID CO

j) Intervention type (e.g. Advocacy, infrastructure, etc.)

Rationale: to have a first look at the portfolio against all the data as a preparation for further analysis and decision making and to judge which criteria may be relevant in the process. See the first tab (Country choice criteria) of Annex O (Excel file) "Sampling process" for full info on the data gathered at this stage.

One country per geographic area (West Africa, East Africa, South Africa and Asia) was selected based on how many projects would potentially represent a good coverage of the other criteria (above).

Result: Myanmar[6], Sierra Leone[7], Uganda[8] and Zambia[9].

3rd: Data gathering and categorisation for all the ongoing projects in the four selected countries against the following criteria and analysis and selection of 12 projects:

a) Health focus (e.g. child health, mental health, etc.)
b) Size of the grant.
c) Length of grant.
d) Range of partners (e.g. education, health, etc.).in the UK and overseas.
e) Grant type (e.g. Long-term volunteering, etc.)
f) Type of intervention (e.g. training, advocacy, etc.)

The data gathered confirmed that the selected countries had projects covering all the health focus areas of the portfolio. See second tab (number of projects per health area) of Annex O for a table with all the projects per country per health area. Health focus was the primary selection criteria at this stage followed by b)-e) above.

Result: Twelve projects were pre-selected (3 for each country). Please see third tab in Annex O for full information on the list of projects, the specific reasons for choosing each of them and how they match the selection criteria. The selection process also included a light review of project design documents in order to assess the type of approach. The selection covers types of interventions – some that have a focused approach on particular technical skills, and others that have an approach that is more likely to result in system change.

The pre-selected projects were also matched against the existing performance score spreadsheet developed by developed by THET (they were all green). The evaluation team decided not to use this RAG rating as a decision making criteria at this stage[10].

4th: Consultation with THET and DFID on the 12 proposed projects and the four countries.

The full list of pre-selected projects and other optional projects were discussed in detail with THET. Key recommendations/decisions made during the meeting were:

a) Need to choose one more project for Uganda because one of the initial choices (HPS 1.5 EA30) was very small and only consisted of a planning visit/needs assessment. It was agreed that this project could still be covered, but would only need one or two interviews.
b) An additional project in Zambia replaced a project only needing a couple of interviews in the UK, and to enable inclusion of a substantial MNH project for in-depth review.

THET agreed that the selection of projects was a good representation of the HPS portfolio.

After discussion with DFID, the country choice was confirmed. In particular Myanmar was the preferred South Asia example for the evaluation visits due to the high profile of the partnership work, DFID's commitment and the particular transition context of the country.

[6]For the Asian region, the only possibilities at this stage where India, Nepal and Myanmar. India was excluded from the countries to visit based on conversations with DFID. Between Nepal and Myanmar, the latter was selected because: it had more projects (3 vs 2) and because of the interesting political environment (also discussed with DFID).

[7]Sierra Leone was selected at this stage because of its unique characteristic regarding the support from DFID CO7

[8]Uganda was selected because it has the biggest number of ongoing projects (24, followed by Kenya that has 14).

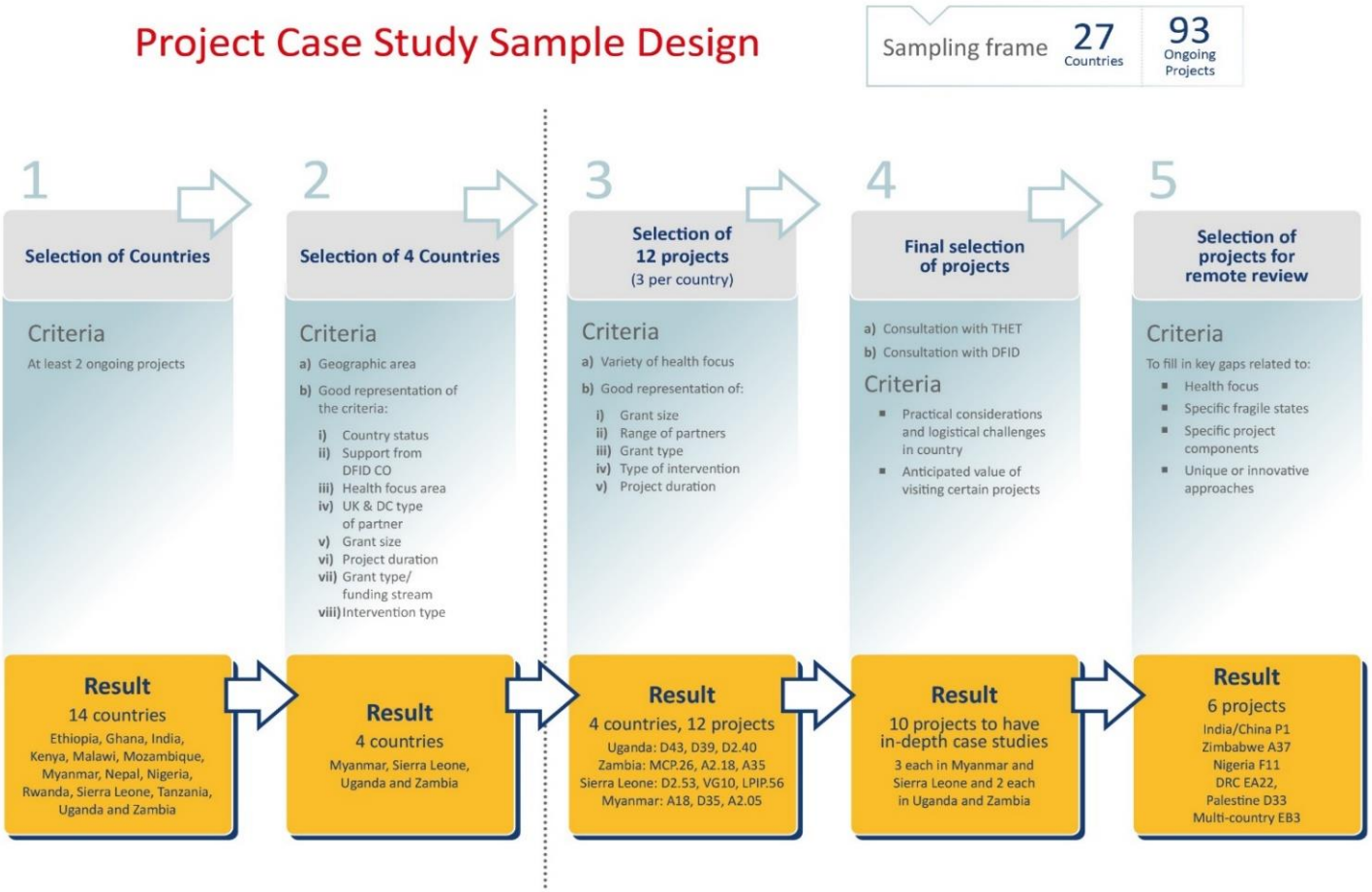
[9]Zambia as a LMIC with a slightly wider selection of projects and of larger size was chosen over Malawi for the S Africa region.

10 There are only 5 projects which have an amber rating (5,37%), in India, Sri Lanka, The Gambia, Uganda and Zimbabwe. There are none with a red rating. Through conversations with THET on the RAG scoring system it was understood that many of the orange rated projects are in that state because they have a later report or some minor issue, rather than because of poor performing issues.

Table 3.2 below shows the final selection of projects in the four selected countries. See Annex O for more details and Annex H for detailed project information on the country case study projects. th: Selection of projects to review remotely

As part of this analysis, other projects were identified as potential projects to review remotely. Some projects have been identified as key to fill in certain gaps in health focus, type of grant and type of partner institutions (e.g. patient safety, health research institution, etc.), It also offered the opportunity to look at some of the innovative or unique examples in the portfolio and to add two projects to cover specific fragile states, one in the MENA region (DRC and Palestine); or for specific strategic components (e.g. African doctors coming to the UK) 11. Table 3.3 below shows the projects selected for remote review.

Figure 10: Project Case Study Sample Design



Statistical representation of the selected projects

The table below shows the maximum statistical representation of the sample[12].

[11]HPS 1.5 A2.15 Kenya: long-term volunteers and African doctors coming to the UK to be trained.
HPS 1.5 F2 or F12 in Kenya and India respectively: to fill in the gaps of F2 type of grants and patient safety health focus
HPS P1 India: only project where the overseas partner is a health research institution; interesting partnership between NICE and China National Health Development Research Centre (CNHDRC). A big (£950K) and long (over 4,5 years) project implemented both in India and China. "Improving the legitimacy and efficiency of healthcare resource allocation through the systematic use of clinical and economic evidence and social values in decision-making. It is also the only ongoing Pilot grant (there were 2 in total) but accounted for 6% of the total budget

[12] The estimation is to look in depth at a total 8 projects during the country visits. In the current active grants there are; 12 health focuses, 10 grant streams, 4 types of UK partners, 6 types of DC partners and 9 types of interventions. The size categories used are: <£50k, £50k - £100k, £100k - £250k, and >£250k. The length categories used are :< 12 months, 12 – 24 months and >24 months. The proportion of funding is calculated over the total ongoing grants as per THET data March 2016.

Table 3: Coverage of sampling criteria

Criteria	Visited projects only	With remote projects
Health focus	75%	92%
Size categories	100%	100%
Length categories	100%	100%
Types of ongoing grant streams	50%	90%
UK partner types	100%	100%
DC partner types	67%	100%
Intervention types	67%	78%
Proportion of funding	6%	19%

Sampling of UK and international stakeholders

UK stakeholders, who are not HPS partners, were identified through the UK government International Health Group. There was no emphasis on stakeholders who have a policy role in relation to volunteering in the health sector, employment conditions and also policy on quality of care and human resource issues.

Volunteers for interviewing in the UK were self-selecting through the survey, and six volunteers were chosen for in-depth interview.

Interviews with international stakeholders prioritised countries and organisations with an interest in partnerships and implementing similar programmes. They included European donors, through ESTHER and directly – with a focus on Germany, Norway – and the USA.

The following projects were reviewed:

Table 4: Country Case Study Project Sample

	Code	Health focus	Size	length month	UK partner	DC partner	Project title and main reason for choosing
Uganda	D43	Palliative health	£248,428	23	University of Edinburgh	Makerere University	Development of Nurse Leadership for Palliative Care in Uganda. Only palliative health project in the selected countries
	D39	SRH	£72,355	23	Royal College of General Practitioners	Bwindi Community Hospital	RCGP / Bwindi Community Hospital Partnership to strengthen the capacity of the health system in South-West Uganda to promote sexual and reproductive health (only SRH project)
	D2.4	General health	£197,120		University of Salford	Multiple	System type project - scaling up medical equipment knowledge exchange in Ugandan hospitals
Sierra Leone	D2.53	Infectious disease	£134,507	19	Plymouth University	Masanga Hospital	Building capacity and sustainability within Sierra Leonean Health Service to improve resilience to future outbreaks of Viral Haemorrhagic fever. Only infectious disease project
	VG 10	Child health	£834,928	51	Royal College of Paediatrics and Child Health	West Africa College of Physicians	Reduce infant and child mortality. Second largest project and very long. Only ongoing long term-volunteering project. Volunteering grants make 14% of the total HPS budget for grants. It includes UK visits by African doctors.
	LPIP.56	General health	£114,482	54	Kings Centre for Global Health	University of Sierra Leone	King's Sierra Leone Partnership health education strengthening project. One of the only 3 ongoing large paired institutional partnership (LPIP) projects. LPIP is 9% of total budget.
Zambia	A2.18	MNH	£201,557	24	University of Manchester	Nurses and Midwifery Association	Supporting evidence-based midwifery practice through audit and feedback: a LAMRN project in Kenya, Uganda and Zambia. Only MNH project to be reviewed.
	A35	Mental health	£99,970	23	NHS Highland	Chipata General Hospital	Mental health literacy and improved patient safety: empowering communities.
Myanmar	A18	A&E	£196,808	27	Cambridge University Hospitals	Yangon General Hospital	Enhancing Trauma Patient Outcomes through Hospital Training Partnership
	D35	Child Health	£236K	23	Royal College of Paediatrics and Child Health	Myanmar Paediatrics Society	Emergency Paediatric Care: Working in partnership to improve the quality of hospital care for seriously sick / injured children and newborns through an ETAT+ package of training with ongoing support and mentorship, leading to sustained changes practice.
	A2.05	Other	£83,461	23	Royal College of Surgeons Edinburgh	Yangon Hospital	Developing Surgical capacity in Myanmar through training

Table 5: Project Choice for Remote Case Studies

Code	Health focus	Budget	Partners	Country	Title
P1	Policy	£954,370	NICE and China National Health Development Research	China / India	Improving the legitimacy and efficiency of healthcare resource allocation through the systematic use of clinical and economic evidence and social values in decision-making.
A37	MNH	£165,440	North Bristol NHS Trust & Catholic Bishops Conference	Zimbabwe	Replicating success: the dissemination of PROMPT - an effective maternity quality improvement package of in-hospital training, tools and performance monitoring
F11	Patient Safety	£57,000	University of Sheffield & Bayero University Kano and Aminu Kano Teaching Hospital	Nigeria	Strengthening systems necessary for improving patients' safety and quality of health care in tertiary hospitals in northern Nigeria
EA22	A&E	£7,000	Kings Centre & Bas Congo Ministry of Health	DRC	To strengthen capacity in the field of trauma training, trauma system development and trauma clinical care in the Bas Congo province of the Democratic Republic of the Congo.
EB3	Eye Health	£191,695	LSHTM	Multiple	Vision 2020; Uganda, Zambia, Tanzania, Kenya, Malawi, Nigeria, Ethiopia

Sampling of evaluation participants in the country was led by the host partners and supported by the volunteers and the institutions that they were working in or with (e.g. hospitals, universities, professional associations). The evaluation team found that saturation had likely been reached towards the end of the evaluation period as the same messages were coming up repeatedly, especially from volunteers and trained health workers in the host countries.

Overall the evaluation covered 17% of all of the 93 current projects (or 37% including the country workshops) and 23% of 66 current lead partner organisations. There were 350 interviews and Out of 890 volunteers in current HPS projects, 41 in depth interviews with conducted volunteers (5%), and 113 volunteers responded to the survey (13%). (There are a total of 66 current grant holders – 50 with one project, 9 with two projects, 4 with three projects, 2 with four projects and 1 with seven projects).

3.2 Evaluation methods

Methods and data collection tools were developed with the help of a literature review during the inception period covering issues around partnerships, volunteering, gender equality and social inclusion in the health system, capacity strengthening in health systems and general background and policy issues.

Most primary data collection was done using qualitative methods due to the limitation of budget and time and the wide range of project and partner types included in the review. Methods included semi-structured, in-depth interviews, and a small number of participatory discussions with groups. Quantitative methods were used for the three online surveys. There was very little generalizable quantitative data from the projects, but a small sample of data from the MNCH document report has also been collected and analysed.

Interview and discussion guides were developed as first drafts for the inception report and then were adapted and finalised for each country visit after a review of project documentation and initial interviews with the UK partners. Every guide integrates questions around gender equality and social inclusion, about health worker power relations and decision making and capacity building (which is the key activity area for many of the HPS projects)[14]. The first visit, to Sierra Leone, gave the opportunity to test the interview and discussion guides and to adapt during the visit. The guides were subsequently adapted further for the second visit, to Uganda. The online surveys were tested by THET staff and a volunteer.

[14] It has not been possible to include assessment of other cross cutting issues such as human rights, HIV /AIDS, environment and anti-corruption as the interview guides were already very long due to the number of issues that had to be covered.

Data collection took place as follows:

(i) Country case study: visits of between 5 – 10 days and consisting of:

- A one day workshop with HPS partners in two of the countries using a series of participatory exercises to explore the quality of the partnerships, the value and effectiveness of volunteers, the HPS approach to funding and support and its overall effect in the country;
- 2 – 3 day visits with each of the chosen projects, including interviews with the host partner organisation and with active volunteers working in health institutions, health workers involved in the project, other service providers or health facility management in the partner institutions (depending on the type of organisation), university faculty and professors;
- Semi-structured interviews with other key stakeholders.

Preparation for country visits involved THET and the host country partner, who led on identifying the interview and discussion participants and organising the logistics. In Uganda and Zambia THET supported the logistics of the workshops.

All notes from the country visits were written up in an agreed format as the interviews were completed, either on the same day or within a few days of the work. This enabled the themes by evaluation question to be understood by each country case study team as the interview notes were emerging. It also meant that there was a level of quality and uniformity across the whole data set.

(ii) Remote project case study: Remote country case studies involved semi-structured interviews per project by Skype or phone. Interview subjects included 2 or 3 of the following: the host country partner, one key stakeholder (preferably government), a key health worker and a volunteer.

(iii) UK and international interviews: Skype or face to face semi-structured interviews with

- Pre- visit and post visit interviews with UK partners
- THET interviews with management and project maagers
- Key UK stakeholders working on health partnerships or involved in partnership policy
- Donors who are funding partnerships and volunteering – ESTHER, USA, Germany, Ireland, Norway, WHO
- Returned volunteers

(iv) Three online surveys were used to collect quantitative data: Volunteers, UK partners and host partners.

(v) MNCH portfolio document review of project reporting to assess the overall contribution of the HPS to MNCH related changes in the health system and service delivery.

(vi) Further literature review had to be undertaken as a selection of research and evaluation reports about volunteering and the impact on the UK health system were sent to the evaluation team by a number of key informants after interview. Findings from the primary data collection has been triangulated with the key findings from these reports.

Data was collected in an appropriate and respectful manner, taking account cultural ethical and legal concerns. Participants were asked to sign consent forms for the interview and for photographs and digital recordings of the interview. The team used sensitivity about hospital overcrowding and health worker time pressures to plan the evaluation visit – in Sierra Leone this meant not planning a workshop due to the severe shortage of health workers and other university faculty due to the Ebola epidemic; in Myanmar it meant limiting the number of parents of sick children interviewed because of the high level of hospital admissions due to Dengue Haemorrhagic Fever (DHF).

Each country team was made up of three evaluators except for Zambia, which only had two. Quality assurance for data collection was the responsibility of the lead consultant for each country visit. Joint interviews and review of notes by the country evaluation lead was undertaken for every interview. Team analysis was used in country to review each set of findings by project. A country “write-up” was produced by each project and

this was quality assured by the country lead and by the Evaluation team leader, as well peer QA within the team.

Coordination and collaboration were encouraged as part of the evaluation, in line with the Paris Declaration principles. All country visits included interviews with government and a sharing of information and reflections with both government and host partners in the hope of building further ownership of the evaluation. The two country workshops generated a lot of inter-partnership interest and communications, which had not previously been in place. Where possible volunteers and host partners were put in touch with relevant programme staff on donor and civil society programmes that had been included in evaluation interviews, with the hope that coordination would improve. The evaluation has been coordinated with WHO in order to inform global partnering and contribute to wider learning.

Table 6: Evaluation workplan

	Activities	Mar - Apr	May	June	July	Aug	Sept	Oct
	Inception							
1	Data collection preparation							
	Country literature review & interview guides							
	Online surveys upload, test and deploy							
	Country visit preparation							
2	Country visits							
	Sierra Leone							
	Review and revision of methodology and tools							
	Uganda							
	Zambia							
	Myanmar							
3	UK based data collection							
	Remote project case studies - Skype interviews							
	Interviews with returned volunteers in the UK							
	Interviews with UK stakeholders							
	Surveys closed and analysed							
4	Data coding and analysis							
	Project write ups completed							
	All interview notes completed							
	NVivo upload and coding							
	Full analysis and reporting							
5	Reporting							
	Reference and Stakeholder group meeting							
	Country reports finalised							
	First draft Synthesis report						26	
	Comments from DFID and SEQAS							14
	Workshop to discuss Draft Report							
	THET Conference							22
	Final draft of Synthesis report and annexes							31

3.3 Analysis

Analysis has been undertaken in three stages:

(i) For each country case study the full written-up project interview notes or transcripts[16] were analysed by using either NVivo (Uganda and Sierra Leone) or manually (Myanmar and Zambia). Topic areas had been used to write-up all interview notes so the notes were easily cut up into relevant areas useful for analysis by evaluation question and sub-question. The analysis was used to write up a report for each project (three reports each for Myanmar, Uganda and Sierra Leone and two reports for Zambia).

(ii) The project reports were analysed along with other data coming out of the country visit (e.g. the workshops and other stakeholder interviews that were not project specific). The country report was written using this analysis. For the remote project case studies a short project report was produced using interview notes directly.

(iii) All project reports and interview notes plus qualitative responses to the surveys were uploaded and coded in NVivo. Analysis was undertaken by code – each of which directly maps onto an evaluation question. Quantitative data from the surveys and data from the MNCH document review was analysed alongside the NVivo coded data in order to produce the final synthesis report. A quality of evidence and triangulation table showing how the main conclusions are backed up by different sources of evidence can be seen in on the following page.

All references and written evidence sources are provided in the bibliography at Annex 10.8 and all interview and discussion sources are provided in the list at Annex 10.9 (for confidentiality it is recommended that the interviewee list is not published when the full report is published)

[16] We used both interview notes and transcripts depending on the context and the country evaluation lead practice. There was no loss of detail with the use of notes as they were very thorough and included significant verbatim quotes that could be used for analysis and reporting.

NVivo Nodes

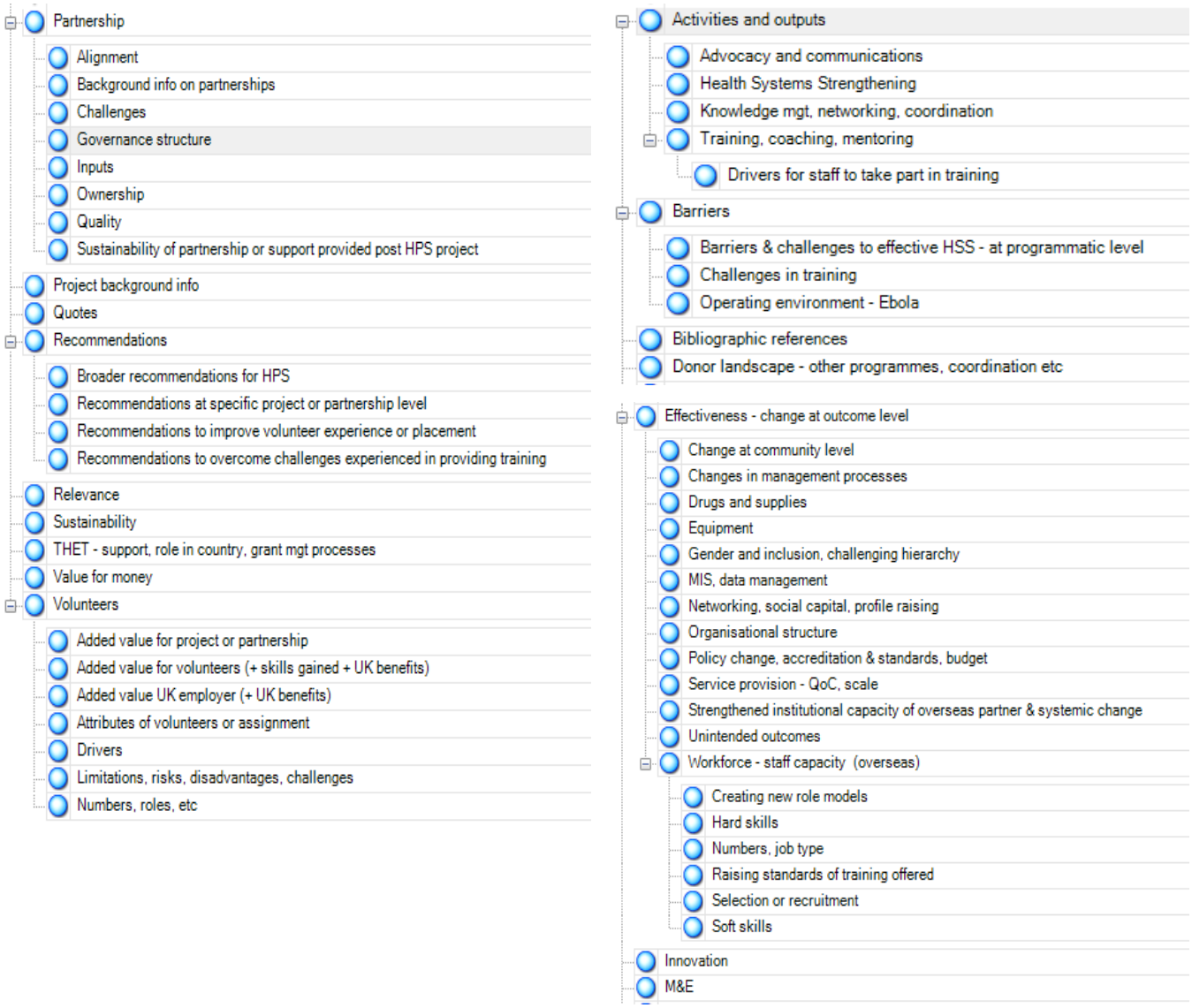

Partnership
Alignment
Background info on partnerships
Challenges
Governance structure
Inputs
Ownership
Quality
Sustainability of partnership or support provided post HPS project
Project background info
Quotes
Recommendations
Broader recommendations for HPS
Recommendations at specific project or partnership level
Recommendations to improve volunteer experience or placement
Recommendations to overcome challenges experienced in providing training
Relevance
Sustainability
THET - support, role in country, grant mgt processes
Value for money
Volunteers
Added value for project or partnership
Added value for volunteers (+ skills gained + UK benefits)
Added value UK employer (+ UK benefits)
Attributes of volunteers or assignment
Drivers
Limitations, risks, disadvantages, challenges
Numbers, roles, etc
Activities and outputs
Advocacy and communications
Health Systems Strengthening
Knowledge mgt, networking, coordination
Training, coaching, mentoring
Drivers for staff to take part in training
Barriers
Barriers & challenges to effective HSS - at programmatic level
Challenges in training
Operating environment - Ebola
Bibliographic references
Donor landscape - other programmes, coordination etc
Effectiveness - change at outcome level
Change at community level
Changes in management processes
Drugs and supplies
Equipment
Gender and inclusion, challenging hierarchy
MIS, data management
Networking, social capital, profile raising
Organisational structure
Policy change, accreditation & standards, budget
Service provision - QoC, scale
Strengthened institutional capacity of overseas partner & systemic change
Unintended outcomes
Workforce - staff capacity (overseas)
Creating new role models
Hard skills
Numbers, job type
Raising standards of training offered
Selection or recruitment
Soft skills
Innovation
M&E

Table 7: Evidence quality and Triangulation table

This table should be read alongside the Conclusions (Section 7 of the main report) so that the full text can be understood.

Conclusions	Evidence source category						Evidence in relation to the Theory of Change assumption and average rating
	Country case studies	MNCH Portfolio review	Recent research on volunteering plus UK and international interviews	Remote cases	Volunteer survey	Partner survey	
(i) HPS projects and partnerships have successfully contributed to health system strengthening	Strong	Medium	Medium	Limited	Limited	Limited	6. Medium
• A higher chance of sustainable and systemic change if…	Strong	Medium	Limited	Medium	Limited	Limited	6. Medium
• Focused technical approaches…	Medium	Medium	N/A	N/A	Limited	Limited	Limited
• The combination of training and mentoring with curriculum…	Strong	Medium	N/A	Limited	N/A	N/A	6. Medium
• Health workers benefitting from training, mentoring…	Strong	Strong	N/A	N/A	N/A	N/A	12. Medium
• While there is some evidence of impact…	Limited	Limited	Limited	N/A	N/A	N/A	11. and 12 Limited
• Health worker ability to improve service delivery is limited by several health system constraints…	Strong	Limited	Strong	Medium	N/A	N/A	12. Strong
• The theory of change shows how some stages…	Strong	N/A	Medium	N/A	N/A	Limited	Medium
(ii) The HPS is an effective way of enhancing partnerships and elements of health system strengthening through partnership approaches.	Strong	N/A	N/A	Medium	Medium	Strong	1. Strong
• Funding to support the development of new partnerships…	Strong	Strong	Medium	Medium	N/A	N/A	Strong
• Networking, advocacy and technical assistance support by THET…	Limited	N/A	Medium	N/A	Limited	Medium	Limited
• The funding mechanism is flexible enough to encourage adaption…	Limited	N/A	Medium	Medium	N/A	N/A	Medium
• The HPS does not appear to have a standardised approval process…	Limited	N/A	N/A	Limited	N/A	N/A	Limited
• THET have worked hard to manage a very high volume of grants…	Strong	Strong	N/A	Medium	Limited	Strong	Strong
• THET, as fund manager, enjoy a high level of autonomy with decision making…	Medium	N/A	Limited	Limited	N/A	Limited	Limited
(iii) Some projects have also enhanced women's opportunities, skills, knowledge and confidence which has the potential for wider economic empowerment for women, though most projects are gender blind.	Strong	N/A	N/A	Medium	Limited	Medium	2. and 8. Medium
• A small number of projects have enhanced research and leadership	Strong	N/A	N/A	Medium	N/A	N/A	
• Other projects have provided opportunities for women in non-traditional…	Strong	N/A	N/A	Medium	N/A	N/A	
• However the projects in general tend to be gender blind…	Medium	N/A	N/A	Medium	Limited	Limited	
(iv) Partners and volunteers have a high level of awareness of value for money and the creation of high quality and effective project approaches. The projects represent good value for money and the results are often likely to	Strong	N/A	N/A	Strong	Medium	Strong	9. Strong

Conclusions	Evidence source category						Evidence in relation to the Theory of Change assumption and average rating
	Country case studies	MNCH Portfolio review	Recent research on volunteering plus UK and international interviews	Remote cases	Volunteer survey	Partner survey	
be lasting as project methodology enhances sustainability and they are embedded within long term partnerships.							
• Partners and volunteers save money…	Strong	N/A	N/A	Medium	Medium	N/A	Medium
• The cost of technical assistance using a partnership and…	Strong	N/A	Limited	Limited	N/A	Limited	Medium
• Value of the HPS partnerships and projects to partners…	Medium	N/A	N/A	Medium	Medium	Strong	Medium
• Given the complex nature of health systems and the need…	Strong	Medium	Limited	Limited	N/A	Limited	11. and 12. Medium
• The HPS has limited in-depth assessments and understanding…	Strong	Limited	N/A	Limited	Limited	Medium	Medium
• The lack of synergies with other aid programmes…	Strong	N/A	N/A	Limited	N/A	Limited	Medium
(v) Efficiency of fund management is good, with sufficient utilisation of funds and reports by partners of good quality fund management and technical assistance inputs. However some systems could be tightened up.	Medium	N/A	N/A	Limited	N/A	N/A	9. Medium
• A number of projects have had slow expenditure…	Strong	N/A	N/A	Limited	N/A	N/A	9. Medium
• Management fees for projects are very wide ranging…	Strong	N/A	N/A	Limited	N/A	N/A	9. Medium
• Partners are not recording their own financial or “in-kind” contributions…	Strong	N/A	N/A	N/A	N/A	N/A	9. Strong
• The management allocation is currently 17% of the overall…	Strong	N/A	N/A	N/A	N/A	N/A	9. Strong
(vi) All projects were found to be highly relevant, and in line with government commitments and supportive of southern partner priorities. However there was a lack of knowledge of other relevant aid programmes and only a limited examples of partnerships that were working in synergy together, which is a lost opportunity.	Strong	N/A	Limited	Limited	N/A	Limited	1. and 7. Medium
• Partnerships that had implemented previous projects…	Strong	N/A	N/A	Limited	N/A	N/A	1. Medium
• There is very limited analysis of or approaches to address gender…	Strong	N/A	N/A	Limited	Limited	Limited	2. Medium
• Project proposals do not appear to require an assessment…	Strong	N/A	N/A	Limited	N/A	N/A	Medium
(vii) Partnerships were a key strength to the approaches seen in the HPS and the quality of the partnership supported good quality projects and effectiveness.	Strong	N/A	Limited	Strong	Medium	Medium	1. Strong
• A number of partnerships are built on trust, mutual respect…	Strong	N/A	Limited	Strong	Medium	Medium	1. Strong
• Projects have been more successful when implemented by more…	Medium	N/A	Limited	Medium	Limited	Limited	1. Medium
• The use of long term volunteers and empowering behaviour…	Strong	N/A	N/A	Medium	N/A	N/A	Strong
• UK partners have occasionally provided institutional strengthening…	Strong	N/A	N/A	Limited	N/A	Medium	Medium
• The allocation of project and financial management roles…	Medium	N/A	N/A	Limited	N/A	N/A	Medium
• Coalitions or networks of partnerships (such as the MNCH Hub…	Limited	N/A	N/A	N/A	N/A	N/A	Limited
(viii) While there was the intention to build networks and strategic joint working at country level the HPS has not been able to do this yet and this might be undermining the potential for a more strategic approach.	Strong	N/A	N/A	N/A	N/A	N/A	Medium

Conclusions	Evidence source category						Evidence in relation to the Theory of Change assumption and average rating
	Country case studies	MNCH Portfolio review	Recent research on volunteering plus UK and international interviews	Remote cases	Volunteer survey	Partner survey	
• There is clear demand for more networking and learning…	Strong	N/A	N/A	N/A	N/A	N/A	Strong
• The role of the THET offices in supporting networking locally…	Strong	N/A	N/A	N/A	N/A	N/A	Strong
• The funding streams do not have vehicles for encouraging country level strategic funding.	Strong	N/A	N/A	N/A	N/A	N/A	Strong
(ix) The type of volunteering and the way it is managed from the UK partner(s) and the host partner(s) has an influence on how effective the project is, on the uptake of new learning and skills by health workers and on the outcomes for the UK health system.	Strong	N/A	Medium	Medium	Limited	Limited	4. and 6. Medium
• Long term volunteering shows a greater potential…	Strong	N/A	Medium	Medium	N/A	N/A	6. Strong
• Short term volunteering works best when it is strategically planned…	Medium	N/A	Limited	Limited	N/A	N/A	6. Medium
• Diaspora volunteers can be more effective in situations…	Strong	N/A	N/A	Medium	N/A	N/A	6. Medium
• Volunteers were particularly effective in bringing new ways of training…	Strong	N/A	N/A	Medium	Medium	Medium	6. Strong
• There are risks of volunteering related to insufficient expertise…	Limited	N/A	Medium	Limited	N/A	N/A	6. Limited
(x) Volunteers gain a number of new skills, self-confidence and new levels of motivation and appreciation of the NHS. There is some evidence that they bring these back into the workplace in the UK and the health system benefits.	Strong	N/A	Medium	Strong	Strong	Strong	4. and 5. Strong
• The type of UK partner sending the volunteer…	Limited	N/A	Limited	Limited	Limited	Limited	3. and 4 Limited
• There are examples of strategic learning approaches to volunteering…	Limited	N/A	Strong	Limited	Limited	Limited	3. and 4. Limited
• There is some evidence that volunteers, their institutions and…	Limited	N/A	N/A	N/A	N/A	N/A	Limited
(xi) THET's efforts to improve data collection and the quality and type of data have been appreciated by the partners and have resulted in the potential for some useful outcome level data by the end of the programme. However there is still a lack of data on synergies and coordination between partnerships and other programmes, and data analysing gender equality with the health system and service delivery.	Strong	N/A	N/A	Limited	Limited	Limited	10. Medium
• Several Southern partners did not have any ownership of the M&E…	Strong	N/A	N/A	N/A	N/A	Limited	10. Medium
• The better quality M&E systems seen in the evaluation were…	Limited	N/A	N/A	N/A	N/A		10. Limited
• There is some evidence that data collection techniques by…	Medium	N/A	N/A	N/A	N/A	Limited	10. Limited
• The indicators showing progress on partnership development were…	Limited	N/A	N/A	Limited	N/A		10. Limited
(xii) The programme log frame needs to ensure it has indicators that are clearly	Limited	N/A	N/A	N/A	N/A	N/A	Limited

Criteria for rating the strength of evidence that has led to the conclusions – balancing considerations of quantity (the extent to which perspectives have been triangulated), quality (the credibility of sources) and consistency. Factors considered when assessing the quality of data included:

Completeness of data;

Objective vs. subjective sources;

Range of sources of data (triangulation within each case study)

Table x – Criteria for Rating Strength of Evidence

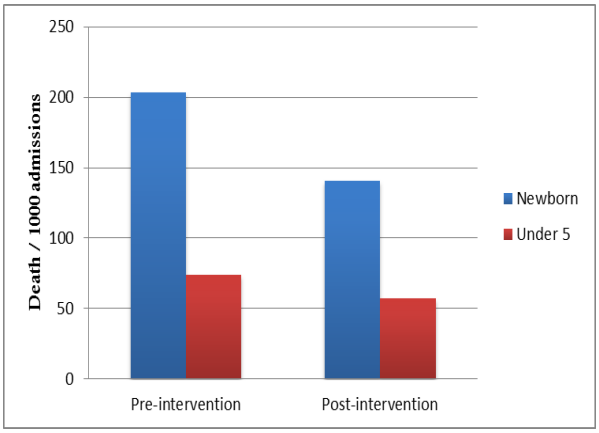
	Strong (=3)	Medium (=2)	Limited (=1)*
Quantity	3+ perspectives	2+ perspectives	Single observation/ perspective
Quality	Very credible	Moderately credible	Some doubt over credibility
Consistency	Fully consistent	Broadly consistent	There is some divergent evidence (which is noted)

Annex 4: Additional detail of Findings

4.1 Impact

Independent evaluations: Of the three independent evaluations in the MNCH portfolio, there is little evidence of broader impact. The first, a twinning project between midwifery associations in the UK and Uganda, Cambodia and Nepal (MCP.3), only showed evidence of strengthening of the midwifery association in Nepal with a 156% increase in membership during the project period and a 93% increase in Cambodia. While increasing membership may well result in an improvement in the capacity and performance of a critical cadre in the health system for more effective MNH outcomes, the longer term impact of this is unknown. The second, a research focused project to improve and increase midwifery research generated in Kenya, Malawi, Tanzania, Uganda, Zambia and Zimbabwe (MCP2.2), concluded overall that "due to the inherent long-term nature of capacity building projects and lack of comprehensive base-line data, measurement of project impact is not possible within the 2-year time frame of the project." The third, a VSO project in Malawi, concluded that it is unlikely that the project will have any sustained impact beyond the project lifetime, and within the project lifetime the impact of the project is limited due to weak M&E systems. Though there was some evidence in change of practice, it was not thought to be sustainable and attribution of impact would be difficult due to the presence of other partners.

Figure 11: Trend of neonatal and U5 hospital death rate pre vs. post intervention in Bushenge Hospital



In the remote case study of the NICE International project in India and China (P1), an Itad Evaluation of the project's work in India (Kerala) only reported small examples of anecdotal evidence on impact on health services and women's health. The overall MNCH portfolio review showed that only 8% of the projects reported any findings related to the intended HPS programme impact. Despite the fact that ETAT+ projects with RCPCH, MCP1, started before THET imposed mandatory M&E plans on grant holders, this project presents positive results in terms of comparison of mortalities in six Rwandan hospitals pre- and post- intervention during the three year project. (see figure x)

The country visits provided further evidence of encouraging results:

- In Uganda, a review of the relevant service statistics showed that significant numbers of patients/ clients have received services from medical staff trained through the projects reviewed. These patients are likely to have benefited from improved quality of care as a result of the training. However, based on the information available, it was not possible to assess whether there has been an increase in the number of services provided/patients treated. Improvements in drugs and supplies, indicating delivery of higher quality services, were also reported in the three projects although this was not the main focus of any of the projects but was a relevant integrated element in each and noted to be important in their overall effectiveness and contribution to improved service delivery.
- In Myanmar, the Emergency Paediatric Care project (D35) was the only one of those reviewed to demonstrate changes in service delivery, though an increase in health professional capacity and skills in the other projects indicates the potential for improved services. Child mortality had decreased in the three months period April to June 2016 from 5% to 2% of child admissions, and from 9% to 5% of newborn admissions in Monywa Hospital, the period since training and the introduction of two UK volunteers. However the figures should be used with some caution as there may be some seasonal or other variations that have not be reported. In two of the three hospitals in this project improved practice overall was reported by nurses, particularly related to infection prevention effective triage system and resuscitation skills. In the trauma project (A 18), the pathology department had achieved an impressively reduced turnaround time of the samples (from 6-24 hours to 2 hours) and with quality

control systems and procedures in place (e.g. analyser specific and individual specific competency assessment) (UK volunteer, progress report and verified during visit).

- In Zambia, the team could not find evidence of impact yet as in the mental health project coverage is small and rehabilitation work is still ongoing hence they were unable to gauge impact on client satisfaction and improved quality of care. In the LAMRN project, clinical audit data are just being collected and analysed.

4.2 Grant mechanism management

Evolving mechanisms

THET use its learning from HPS and previous experience (e.g. IHLFS) to continue developing and improving the systems and procedures around grant making. HPS 1.5 is, for example, based on more structured MEL processes and systematic project reviews. "We strengthened the process, the support we gave, the templates were all better" (from THET interview). The HPS grant management manual is a living document and an example of THET's strive to learn and improve systems and procedures. This "evolving" grant management nature, means that different type and sets of data have been made available at different times of the HPS programme, making challenging sometimes, from an evaluation point of view, to get certain standardised data for the whole portfolio from the inception of HPS (e.g. there is more M&E data from recent grants-HPS 1.5- than from the original ones).

Tailor-made systems and requirements

THET have tried to adjust some of the grant systems to the size of the grants to reduce, for example, the reporting burden on smaller grants. As an example, the small start-up grants (which usually fund a few country visits or a needs assessment for a small budget and short time) are not required to submit progress reports, but only a completion report at the end of the project. The application process for this grant scheme is also a simplified version. These "tailored" processes are extremely beneficial for the UK partners and new applicants but come at a managing cost for THET.

Different grant schemes

The projects are selected in different calls for proposals for different grant streams. Each grant stream has a specific purpose in terms of what the activities of the grants try to achieve. They also have specific size, duration and eligibility criteria. Table 1 below presents a list of the grant streams and the number and value of grants allocated by stream.

Table 8: HPS funding streams

Scheme	ID	Full name	TOTAL	Ongoing	Completed closed failed	TOTAL VALUE
HPS 1.5	D	Additional support for the HPS Community	31	30	1	£3,420,056
HPS 1.5	A	Additional support to HPS Partnerships to build on and/or replicate successes (invitation only)	28	28	0	£3,782,137
HPS	MPIP	Medium Paired Institutional Partnerships	26	2	24	£649,892
HPS	SPIP	Small Paired Institutional Partnerships	26	0	26	£128,813
HPS 1.5	EA	Support for UK health sector engagement overseas through Health partnerships a) Strategic engagement with UK institutions on health partnership development	17	15	2	£105,314
HPS	LPIP	Large Paired Institutional Partnerships	12	3	9	£1,933,279
HPS 1.5	F	IPC grants - Infection Prevention Control	8	8	0	£317,498
HPS	MCP	Multi-country partnerships	7	1	6	£6,265,522
HPS	MEG	Medical Equipment Grants	5	0	5	£111,570
HPS 1.5	EB	Strengthening different approaches for health partnership engagement	5	4	1	£573,021

HPS	VG	Long-Term Volunteering Grants	4	1	3	£3,051,227
HPS	LPIP VB	Voluntary bursaries for LPIPs	4	0	4	£59,399
HPS	P	Pilot Grants	2	1	1	£1,358,370
HPS 1.5	C	Knowledge Exchange and Sustainability Grants	1	0	1	£5,150
Total						**£21,761,248**

As mentioned below, THET has had full autonomy to design the strategic purpose and characteristics of the different grant streams. However, at least in one occasion, DFID, exclusively, took the decision of funding a specific grant (managed by NICE), which implied THET was not involved in the strategic decision process and the grant was not set up following the same procedures as the rest of the portfolio. There have been large underspent funds under this grant and the eventual project was quite different from the grant proposal. This resulted in a situation where NICE was implementing a project that was not necessarily within their technical expertise area.

When surveying the UK partners during this evaluation, we found that most respondents (67.8%) agreed with the statement: “The grant streams have a strategic focus”.

Too many too small grants?

Overall, THET has given out 176 grants since the beginning of HPS (approximately 30 grants per grant manager currently). Managing this number of grants and making sure they get the right support and monitoring, has proven very challenging. “It would have been nice to have a smaller number of larger grants that would have eased that. This would have allowed more depth of understanding and support” (from THET interview). The different timeframes of the different projects also present a management challenge to THET. This may have affected THET’s ability to systematically collect common findings and learning to be strategically used in the grant making process.

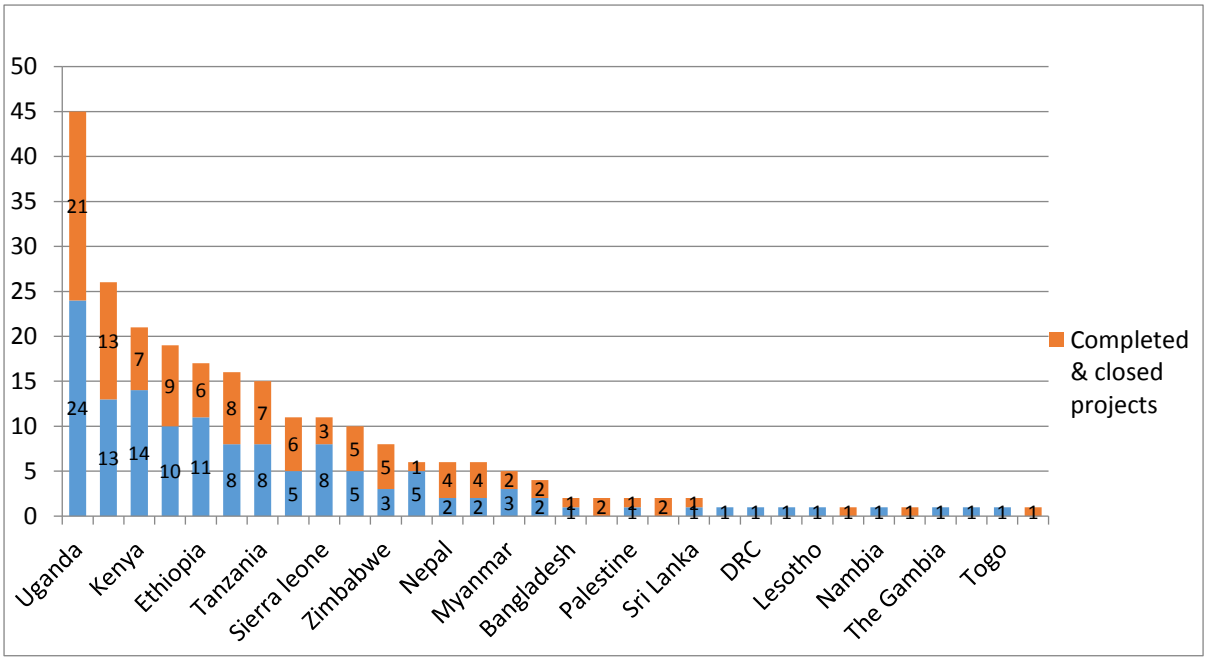
On the other hand, it is mainly the small grants that have enabled the HPS, and THET, to test different approaches to effective partnership working, and through which THET have learnt and evolved. . This is demonstrated by: “Part of the criteria around the HPS was creating an enabling environment for partnerships to thrive in the UK. The smaller grants have helped to do that.” (from THET interview)

Our view is that approaches that have proven to work through smaller, earlier grants (whether they are HPS or not) could benefit from follow on larger scale funding to enable projects and partnerships to scale up or replicate effective approaches. At the same time, it is important to maintain the provision of smaller start up grants as these enable partnerships to test approaches and build foundations for potential later scale up or replication.

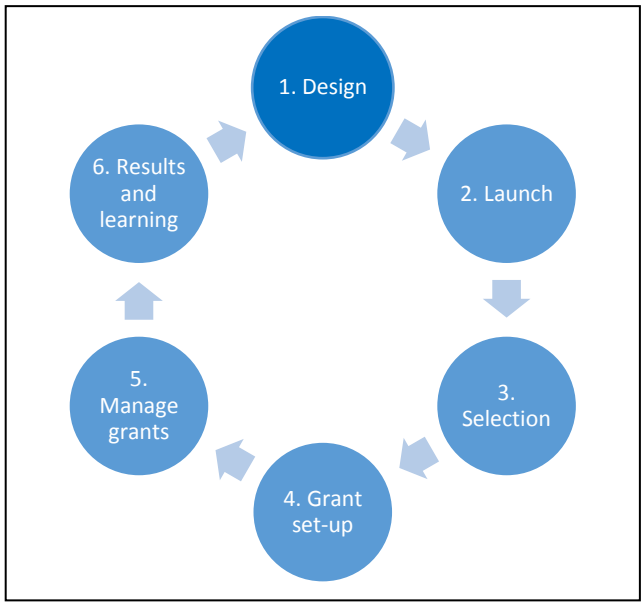
HPS grants’ geographic distribution

HPS grants have been concentrated in a small number of countries (see figure below for the geographic distribution of grants). 72% of grants are in East Africa and 94% are in Southern and East Africa combined with very few grants in other regions. However, this (or the decisions around thematic focus of the projects, type of UK or overseas institution, etc.), does not seem to be a strategic decision but rather the natural result of the demand for funding. It could be argued that the geographic distribution of the grants (and maybe other aspects as well) would benefit from being made more strategic and purposeful.

Figure 13: Number of HPS projects per country



THET's autonomy and sphere of influence as Fund Manager



The picture to the left demonstrates the different stages of the fund management cycle – from design and launch of the fund (or specific windows), to project selection, ongoing management of the portfolio of grants (including fund disbursement), and monitoring, results and learning. THET has played a major role in each step of the fund management cycle. Of note, decisions around the different grant schemes mentioned above (e.g. which ones to make at each stage of the programme and how much funding to allocate to each grant stream or funding window) are made almost entirely by THET – demonstrating a high degree of autonomy for THET as the fund manager in this particular aspect of fund management. Some aspects have been, however, determined by DFID's priorities. For example, in HPS 1.5 there was an extra £10M injection of funds for a two year period. This requirement may have determined the shape of the funding streams because of the time pressure.

Figure 14: Fund management cycle

The decision on what projects to fund under each particular grant scheme also appears to be fully under THET's autonomy. In HPS 1, proposals were appraised by an external panel with THET playing a secondary role in the award process (sometimes interviews and assessments). With HPS 1.5 the approach has evolved to panels with a mix of internal THET and staff and external technical reviewers. In the case of HPS, DFID does not seem to have any major involvement in making the final decisions around which projects to fund. As mentioned above, an exception was DFID's involvement in the decision around funding a specific grant (NICE). In comparison, in the management of other funds, DFID's involvement in decisions around calls for proposals, appraisal and selection of projects may vary to different degrees. For example, with the Global

Poverty Action Fund (GPAF), the fund manager presented a list of recommended proposals to DFID, ranked by appraiser score, for DFID to make the final decision on which projects to fund[17].

Regarding THET's sphere of influence, this seems to be a mix of non pre-defined programme outcomes, some capacity building support (particularly in the area of monitoring and evaluation) and indirect measurement of project results with performance management systems based mainly on six monthly progress reporting and sampled country visits.

Figure 15: Fund manager sphere of influence

Coordination and strategic focus of grants within countries

As observed during the country visits implemented during this evaluation, there is room for improvement of the coordination of existing grants and projects within each country. THET is definitely making efforts to improve this coordination and networking (e.g. through regular country focused webinars and THET country offices) but the evaluation team found that often neither the overseas nor the UK partners were aware of other HPS interventions in the same overseas country.

There are also questions around how to make HPS more strategic within each particular country (e.g. focussing on specific health themes or sectors or making sure the different efforts complement each other), and whether this would increase overall's HPS effectiveness in achieving the overall goal of strengthening health systems.

4.3 Value for money

4.3.1 HPS partner concern and implementation of VfM principles through project cycle

All of the projects reviewed for the country case studies and the interviews for the remote case studies demonstrated a ***high level of awareness of and commitment to the importance of economy (in particular), efficiency and effectiveness as well as sustainability***. There is a strong culture and practice of cost minimisation across all projects, using low cost transport, conducting training in health facilities, and combining different cohorts of trainees to avoid extra costs. This is partly because of the nature of partnerships ("*you hit the ground running"*) and most of those implementing the HPS projects from the UK are volunteers and only have basic living costs covered by the project, so are wary of expenditure.

Awareness of economy and effectiveness – Infection prevention and control project (F11), female long term volunteer, Nigeria

"There is a high chance of change if they (the hospital staff) continue with this trajectory and do not lose momentum. I will come back again at the end of November to continue the training by myself. It feels a bit premature to leave the project – we have just started putting the structure in place and there are parts of the WHO patient safety curriculum that would strengthen their clinics' risk management structure and quality improvement. And I would like to see whether the small changes are making them advance forward. They need that. We did apply for further funding to come back in November but we were unsuccessful. So I have taken it upon myself. I have been meticulous in spending the money for these expenses and I have some money that I can use."

There is also a high level of awareness and responsibility of ensuring project effectiveness. ***Volunteers demonstrated a particularly keen commitment to and responsibility for high quality work, innovation and tenacity in the face of challenges***. Volunteers were also willing to continue giving support for no remuneration either to continue working in country they have been volunteering in with their own or raised funds (EA22 in DRC and F11 in Nigeria), or from their home base. The volunteer survey showed that nearly three quarters of respondents (71%) had continued to provide remote support after they had returned from their volunteering assignment overseas. For most, this took the form of email support, or WhatsApp/skype or

[17] Based on IPE Triple Line and Crown Agent's experience, who managed the GPAF in a joint venture from late 2010 to early 2016.

other forms of social media. The remote support included ongoing mentoring to health workers, as well as support and advice to new volunteers or project management staff overseas.

4.3.2 Comparisons of efficiency and effectiveness with other programmes

When compared to other partnership and volunteering projects the HPS projects have some advantages, but there are also areas for improvement. The HPS has the opportunity to learn from the different approaches being tried out in other programmes. In comparison to wider aid programming the HPS has a clear VfM advantage due to the use of expert volunteers, but there are also areas that can contribute learning in order to improve efficiency. This section compares different aspects of a small number of programme approaches in terms of efficiency and effectiveness.

Building synergies with other aid programmes: Whilst there is evidence (see Partnership and Relevance section) that the HPS projects are often not coordinating or communicating well between each other or with other aid programming, there are clear VfM and sustainability reasons for changing this. VSO are aware of this and have placed volunteers in assignments to synergise with other development programmes, for example in Myanmar they have five volunteers placed in midwifery colleges supporting a JPIEGO 3MDG programme. They also have an expert working on wider health systems strengthening (e.g. HSS expert placed in a township health department), or to provide targeted specialist advice (e.g. SRH specialist, retired public health professor, in the MoH MRH division working on a harmonisation project). They also do CSO capacity building and institution strengthening and work cross sectorally (e.g. NORAD GBV programme in Myanmar work with 2 women's organisations using psychologists, organisational development and knowledge management advisers.). Also VSO provides admin support for their volunteers if necessary and links with the youth programming in the country. In Uganda they support workforce strengthening capacity building (MNH and ToT) and systemic issues such as workforce motivation, referral between district and tertiary hospitals, working with village health teams (VHTs) etc.

Though VSO can do all of this, they generally still only support project specific volunteering placements which are not necessarily sustainable or inked to an institution that can provide a follow on relationship. And while VSO might have good development programme management expertise, they lack the clinical specialist expertise for oversight of a targeted specialist health initiative (e.g. emergency paediatric care or urology surgery). It would not be good value for money to take on a set of specialists to monitor all of the different technical areas, when professional associations, hospitals and universities already have these people. Also in Uganda the VSO project had difficulty recruiting medical personnel – so there was an agreement between VSO and RCPCH.

A major concern with small projects is sustainability. For example Capanamur in Sierra Leone Children's hospital (with the RCPCH project) were providing 50% of all drugs and consumables, volunteer nurses, doctors and other health staff on long term placements and incentives to local health staff. The project ended in December 2015 and now the hospital has a deficit in required drugs.

Making it Happen in Sierra Leone brought in eight volunteer midwives in 2009 to conduct the EmONC and BEmONC training and train master trainers. Over time they have trained national faculty for all of the 14 districts in the country, collaborating through the District Management team who also supports the monitoring of trained providers. The aim was to reach all health facilities. The master trainers are attached to the course director or older trainers for mentoring. e.g. Making it Happen.

The Improving Global Health (IGH) through Leadership Development programme is a unique and innovative scheme run by the Thames Valley and Wessex Leadership Academy (TVWLA) and jointly funded by TVWLA and a grant from the Tropical Health and Education Trust (THET) Health Partnership Scheme (HPS).

The programme recruits volunteers/ from the NHS who are awarded a Fellowship and are known as NHS IGH Fellows; each Fellow completes a placement for 6 months working with an overseas partner in a resource-poor setting. Drawn from all staff groups, the IGH programme enables volunteers to develop leadership skills through project work using system-strengthening methods. The projects, based in a number of overseas locations, contribute to improving healthcare in the local area in a sustainable way. Applicants are usually early to mid-career.

VSO £395 per month for volunteer cost = £2,370 for 6 months

Volunteer survey 3,486 days overseas

Volunteering through Norwegian NGO

Capacity Care (Capacare) is a Norwegian organization set up in 2011. We have since then being supporting Masanga Hospital on taskshifting. This focuses on training CHOs to be able to provide surgical care to patients and become SACHOs. I am the international coordinator of Capacare which I do 50% of my time but I use the remaining 50% to provide both clinical and surgical care to the patients in the hospital. We provide on the job training and mentoring of health workers. We bring in very senior surgeons from developed countries on voluntary basis to teach the CHOs, most of them also provide clinical care during their stay. We provide accommodation, food, and flights for international volunteers. To ensure sustainability we include local surgeons and they are given some allowances and accommodation

Dr. Daniel van Laedeerm- International Volunteer, Capacare.

Table 9: Evaluation country case study projects financial and costs data and outputs for training

	volunteer days overseas	volunteer days in the UK	Total number of volunteers	Total budget	Management % of total expenditure	Major cost drivers	Training unit cost	Total trained	Cost per LT volunteer	To date budget utilisation	Utilisation of total budget in month 12
D2.53 Sierra Leone	419	0	9	£134,057	22%	Training 27% Equipment 20% M&E 20% Travel 11%		28		75% (6m)	
LPIP56 Sierra Leone	334 (562 in total Kings projects)	0	8 (21 total in Kings projects)	£114,482	9.5%	Travel 57% Equip 20%	£201 per person	322		49%	59%
VG10 Sierra Leone[18]	1930	-	7	£834,933	24%	Volunteer 61%	£6.30 per trainee per day	440	£15,450		92%
D2.40 Uganda	127	18	3	£197,120	15%	Travel 30% Training 22% Equip 17% M&E 14%	£200 per trainee/ £4.76 per trainee per day	242		35% (6m)	10%
D43 Uganda	10	29	19	£248,428	20%	Training 49% Travel 18%	£61.81 per trainee per day	94		59%	28%
D39 Uganda	472	44	8	£72,355	21%	Training 34% Travel 21% M&E 13% Misc 8%	£3.62 - £6.30 per trainee per day	422		99%	52%
A35 Zambia	77	105	8	£99,970	20%	Training 33% Travel 16% M&E 20% Equip 10%	£1,000 per person for whole course and ongoing support	37		94%	48%
A2.18 Zambia	10	4	2	£201,557	19%	Training 44.5% Travel 27%	3,000/person for whole course £150 per day?	47		65% (18m)	54%
D35 Myanmar	550	18	16	£236,655.18	18%	Travel 38% Training 25% M&E 16% Equipment 3%	£19 – 38 / person/ day	307		59%	33%
A18 Myanmar	215	78	11	£196,308.00	17%	Travel 60% Training 15%	£202,404 if charged	132		69%	38%
A2.05 Myanmar	77	39	6	£83,461.22	7%	Travel 76% Training 8% M&E 9%	£93/person/day or £400 if including intl travel	287		38%	30%
Total	**4,221**	**335**	**97**	**£2,419,326.40**				**2,358**			

[18] Multi-country project finished July 2016

4.3.3 Cost per health worker trained

Table 10: Cost per health worker trained

Health partnership	Learning outcome	Health worker cadres	Health workers' institutions and countries	Training venue	Duration	Number of health workers trained	Cost per health worker trained	Cost per training day per health worker	Notes
LPIP32 Child and Adolescent Mental Health project (CAMH)	Certificate in CAMH assessment and management	Psychiatrists, psychiatric clinical officers, nurses, social workers, psychologists, occupational therapists	rural and urban hospitals	Butabika School of Psychiatric Clinical Officers in Kampala and institutions around Uganda	1 year	23	£1,915	N/A	Consultant; to February 2015 or earlier; excludes project management costs.
							£2,093 / £1,854	N/A	THET; to February 2015; with / without project management costs at 13%
LPIP32 Child and Adolescent Mental Health project (CAMH)	Diploma in specialised CAMH care, including training as trainers	As above	As above	As above	1 further year	15 (13 completed course) of the 23 above went on to further training	£3,825 per health worker who achieved the Diploma	N/A	Consultant; to February 2015 or earlier; substantially higher than Certificate training because there were fewer trainees while the training costs were roughly the same
MCP26 COSECSA Oxford Orthopaedic Link (COOL)	Primary Trauma Care knowledge and skills	Doctors, nurses, clinical officers, others	At least 45 health institutions in Ethiopia, Malawi, Kenya, Mozambique, Uganda, Zambia, Rwanda, Zimbabwe, Tanzania,	a range of venues largely in their own countries	2 days, or 3 days for those additionally trained as course instructors	1,849	£193	£97 per day per health worker for the two day course	Consultant; to February 2015; excludes project management costs

			DRC and Namibia						
						2,394	£217 / £185		THET; to April 2015; with / without project management costs at 17%
						1,197	£117 / £105		THET; April 2014 to September 2014; with / without project management costs at 11%
MCP26 COSECSA Oxford Orthopaedic Link (COOL)	Specialist orthopaedic knowledge and skills	Surgeons			4 days	126	£856	£214	Consultant; to February 2015 or earlier; excludes project management costs
						94	£558 / £499	£125 / £140	THET; April 2014 to September 2014; with / without project management costs at 12%
MCP26 COSECSA Oxford Orthopaedic Link (COOL)	Improved orthopaedic surgery skills through experience and mentoring in fellowships	Surgeons			1–6 months	36	£5,807	N/A	Consultant; to February 2015 or earlier; excludes project management costs
						34	£963 / £860	N/A	THET; April 2014 to September 2014; with / without project management costs at 12%
MCP1 Working in Partnership to Achieve MDG4 in East Africa: Improving the Quality and Safety of Hospital Care for Sick Infants and Children through ETAT+	Paediatric emergency triage and treatment skills	Doctors, nurses, midwives, clinical officers, others	18 rural and urban hospitals in Kenya, Rwanda and Uganda	18 rural and urban hospitals in Kenya, Rwanda and Uganda	5 days	556	£833	£167	Consultant; to February 2015 or earlier; excludes project management costs
						384	£354 / £275	£55 / £71	THET; April 2014 to September 2014; with / without project management costs at 29%

MCP2.02	Understanding of critical analysis of research and practice	Midwives	Hospitals across Zimbabwe		4 days	17	£572 / £519	£143 / £130	THET; Jan 2014 to April 2014; with / without project management costs at 10%; different costs in each country largely reflect numbers of trainees: course costs are fairly consistent
			Hospitals across Uganda		4 days	20	£486 / £441	£122 / £110	THET; Jan 2014 to April 2014; with / without project management costs
			Hospitals across Kenya		4 days	18	£574 / £521	£144 / £130	THET; Jan 2014 to April 2014; with / without project management costs
			Hospitals across Tanzania		4 days	17	£691 / £627	£173 / £157	THET; Jan 2014 to April 2014; with / without project management costs
			Hospitals across Zambia		4 days	12	£897 / £815	£224 / £204	THET; Jan 2014 to April 2014; with / without project management costs
			Hospitals across Malawi		4 days	20	£615 / £559	£154 / £140	THET; Jan 2014 to April 2014; with / without project management costs
LPIP3	Management of surgical emergencies and training of trainers	Surgeons	East, central and southern Africa	Lusaka, Zambia	6 days	15	£3,658 / £3,463	£610 / £577	THET; September 2012 to April 2013; with / without project management costs at 6%; including TOT day

4.4 Partnership and relevance

4.4.3 Relevance, ownership and alignment

Relevance of UK partner type and diaspora volunteer: Enhancing Trauma Patient Outcomes (A18), Myanmar

"Our needs assessment revealed a clear need for better support of leadership and organisational skills among Yangon General Hospital (YGH) senior officials – so included visits of these decision makers to the UK." This project was working in the Intensive Care Unit (ICU), Pathology department, Physiotherapy and Orthopaedics as a response to a joint assessment. It is a relatively new partnership between YGH and Cambridge Addenbrookes Hospital, giving potential for a whole hospital approach and the opportunity for senior YGH officials to undertake a learning visit to the UK hospital along with technical staff.

The assessment, however, may not have sufficiently built understanding of the cultural context and the training and communications needs in the ICU, and this has resulted in difficulties with targeting and scheduling of training. Notably the arrival of a diaspora volunteer pathologist has improved coordination and accelerated change in the pathology department.

4.4.4 Types of partnership, strengthening and relevance for effectiveness

Longer lasting partnerships have higher resilience (especially in the face of disagreements and challenges) and more effective projects with the exception of:

"Long term relationships we have built up over the years with our colleagues from Chester ensure mutual trust and respect so constructive criticisms can be offered and welcome in both directions. This has led to a more mature understanding of the real challenges and issues and a shared partnership approach to moving forward."

Host partner survey response

(i) Relatively new partnerships which are managing to develop effective approaches due to the existing international experience of the UK partner. For example the RCPCH, with seven HPS projects, have developed an effective approach to building partnerships with professional associations and health delivery institutions in low income countries because of their long experience in development projects, their Global Links (volunteering) programme and their experienced project management staff. The fairly new RCPCH partnership with the Myanmar Paediatrics Society (MPS) was already functioning well with a high level of MPS ownership and collaboration, good project design, alignment with country policy and high potential for scale up and replication.

(ii) UK partners that been working successfully for a long time with a particular partner in a country (e.g. LPIP56 Kings Partnership with Connaught Hospital in Sierra Leone and A37 North Bristol NHS Trust (PROMPT) partnership with Mpilo hospital in Zimbabwe) may have developed a new partnership as a way of expanding a current successful approach (PROMPT with the Zimbabwe Catholic Bishops Conference who manage a large number of hospitals in rural areas and with the continued support of Mpilo Hospital) or as a way of expanding learning to an academic institution (LPIP56). The new partnership does not always work so well and possibly the UK partner has assumed a relationship and a level of understanding with the new partner when it still needs time and effort to develop.

(iii) Not all long term partnerships build ownership and result in good project design; and this is often to do with the attitude and design of the UK partner input. For example D39 in Uganda appeared to be UK partner led and had a series of short term volunteers.

THET and the HPS role in strengthening partnerships has been crucial. The funding has enabled partners to implement projects together and to build their relationships. THET's Principles of Partnership have guided partners on good practice and laid out ground rules that are also empowering for the partners. Nearly all partnerships were following the Principles fairly well and several mentioned the important role that THET plays in the partnership development. From the UK partner survey 76% (n=41) felt that THET had provided inspirational leadership to encourage good partnership working, and 82% (n=44) felt that the HPS Principles of Partnership had been a useful guide to partnership working and effectiveness

4.4.5 In country coordination and synergies with wider HSS programmes

International health priorities are also reflected in the HPS portfolio, with a strong emphasis on Maternal, Newborn and Child Health (MNCH) – 41 (24%) of all 173 HPS projects are MNCH projects, accounting for

46% of the total HPS value. Other health areas are responding to global gaps in health and HSS work (e.g. palliative care (Krakauer and Rajagopoal 2016), infection prevention and control (IPC) and equipment management). Only a small number of projects (e.g. A35 in Zambia) are focusing on building community awareness and the linkage with the health system, which would be an important area for development under the new WHO "people centred and integrated health services" framework.

UK and DFID priorities are represented well in the choice of countries and health areas, and the emphasis on building long term partnerships and international health networking. (see Annex 10.1 for full portfolio information). Also, UK support is thought to be very appropriate in some countries, such as Myanmar, where several health professionals had studied in the UK and there were personal contacts. The Burmese health experts said they have a British system, English is used for all health record keeping (and they cannot understand when they visit Japan and Korea) and so there is a great deal of interest in UK partnerships. "*Because we are all British trained we still love the ways of the British methods. We would still prefer the people from the UK to come and help us*" (Myanmar surgeons D2.05).

There is also ***very little evidence of connections between HPS projects or with volunteering and partnership programmes from other countries*** or through VSO. This can lead to overlap and missed opportunities. This is particularly surprising given the funding that the HPS had given to the Uganda Alliance – demonstrating that giving this responsibility to an organisation that might also be competing for funds is possibly not an effective approach to garner the coordination and co-working needed. There are exceptions to this, for example the RCPCH coordinated with VSO at the beginning of their project in Myanmar and discussed ways in which they could share expertise. There are also coincidental synergies if volunteers are willing to take advantage of opportunities (for example a D35 volunteer in Myanmar met a US volunteer from the Global Heath Service Network in a pizza restaurant in Mandalay. He is an expert in ventilation, trauma, intensive care and transportation and so the HPS volunteer invited him to teach staff in Monywa hospital how to use the ventilation equipment that they had found unused in a cupboard).

Connections with the FCO, DFID offices and DFID programming are almost non-existent, and this is not surprising given the need for DFID staff to prioritise larger programmes. However it is a missed opportunity to support a more strategic engagement with UK partnerships and to promote the role of UK health professionals overseas, especially in countries with a high number of grants (e.g. Uganda with 48 ongoing and completed projects worth £11.2 million over five years and Zambia with 26 projects worth nearly £7 million for over five years[19]). The DFID Myanmar office is the only office that has shown an interest in the programme and has identified partnership as a key area for developing their future health programming.

The potential for linking between partners, with government and with the wider aid community would have been an important role for the Uganda Health Alliance, funded by the HPS and managed by Global Health Exchange. However the project has not been successful in coordinating the Ugandan HPS partners at all in country or the UK partners and there appears to be a lack of understanding about the role of the Alliance.

However, there is an important example to learn from for future coordination planning - the Uganda Maternal and Newborn Hub, funded by THET to start up in 2011 to coordinate and consolidate training across 8 Ugandan Obstetric health care partnerships. This multi-partner vehicle has provided a major investment in the development of audit and evaluation, supports the communication with government in Uganda (thereby cutting down transaction costs for the government) and is the lead organisation for the very successful Medical Equipment project (D2.40) in Uganda, which highlighted the need for whole hospital training, a key element of its success.

[19] Note that some of these are multi-country projects so not all of the budget will be spent in that country.

4.5 Volunteering and UK health system impact

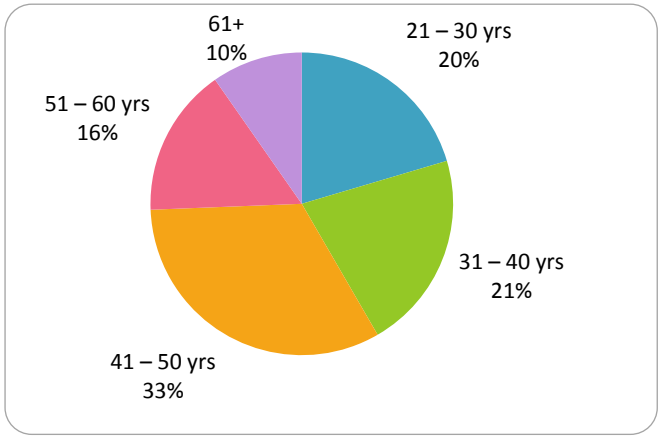
4.5.3 Volunteer profile

Since its inception in 2011, the HPS has engaged 1,700 volunteers through projects across 32 countries, mainly in Africa and Asia, with more than 51,124[20] UK health professional days spent volunteering. Although it would be inaccurate to say there is an "average HPS volunteer", results from the evaluation's online survey with 113 current and returned volunteers do provide an overview profile of individuals choosing to volunteer with the HPS. (The obvious limitation to note is that the survey responses reflect the profile of those who responded to the survey – which is not necessarily wholly representative of all HPS volunteers.)

Basic demographic & professional profile

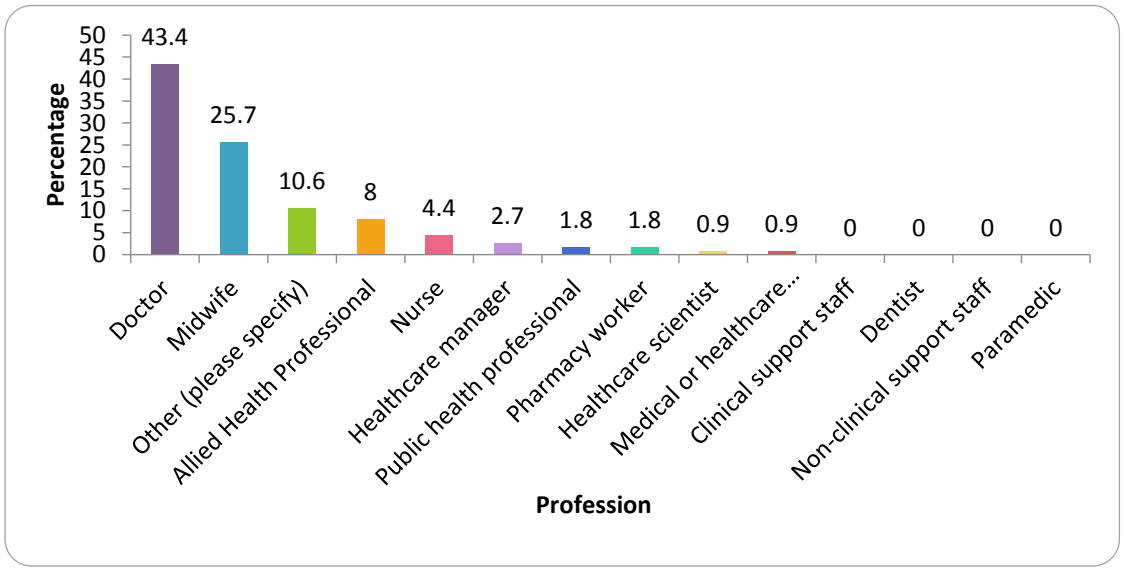
The majority (77%) of volunteer respondents were **female**, with the following age distribution at the time of volunteering:

Figure 16: Age distribution of volunteer respondents



As demonstrated by the graph below, the largest proportion of survey respondents were Doctors (43%) followed by Midwives (26%). Professions listed in the 'other' category included health visitor, trainee health psychologist, student, teacher/lecturer and retired professional.

Figure 17: Profession of survey respondents



Type and nature of volunteer support provided

[20] This figure does not include weekend days spent volunteering.

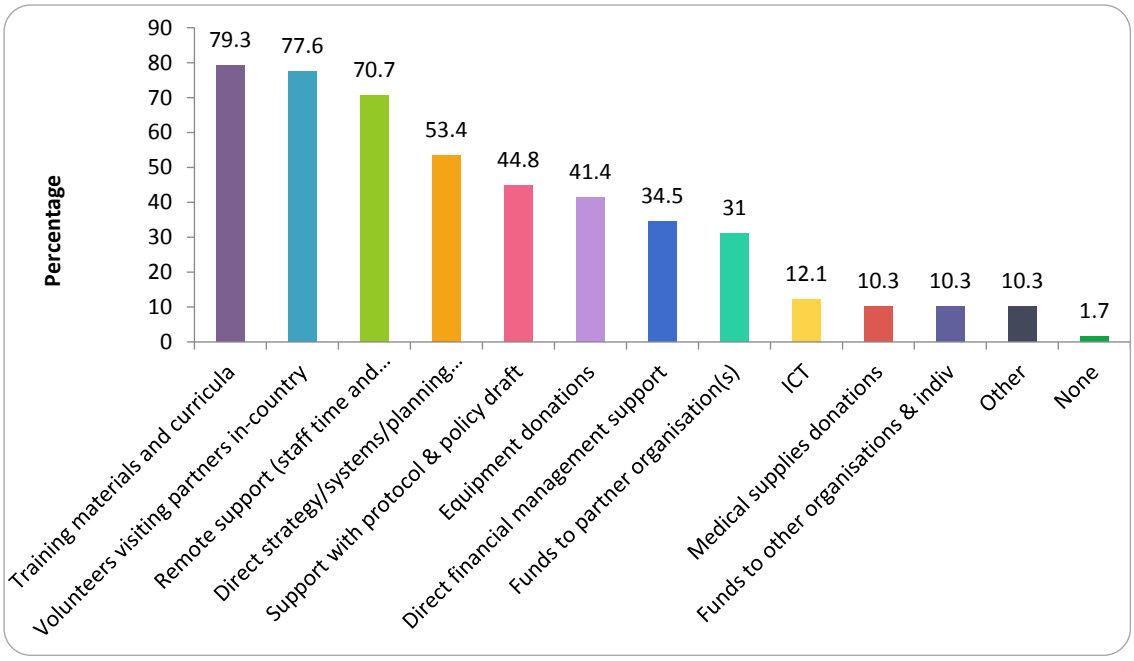
HPS volunteers provide both in-country and remote support to overseas partners and health workers. Evidence from the volunteer survey, country case studies, and interviews with returned volunteers suggests that the majority of volunteers will do **between one and five placements** overseas: in the online survey, 45% had undertaken one placement, 21% had done two placements, and 26% had done between three and five placements.

HPS volunteer placements can be short term or long term, ranging from just a few days spent volunteering overseas to a year or more. The advantages and disadvantages of both types of placement are discussed below.

When in country, HPS volunteers are engaged in a range of different activities and roles. The overwhelming majority of volunteers are engaged in health worker **capacity building or quality improvement efforts** during their placement – and indeed for many this comprises the primary aim of their placement. Capacity strengthening efforts can involve on the job training and/or in-the-classroom training, and in many instances involve ongoing **mentorship, support and supervision**. Capacity strengthening efforts are conducted across a wide range of clinical fields, including but not limited to infection prevention and control, management of childhood illnesses, equipment use and maintenance, sexual and reproductive health and maternal and newborn health. In addition to capacity strengthening, a large proportion of volunteers are engaged in **direct service delivery** – although the extent of this varies hugely by partnership, country and project. As an example, in the 'Building capacity and sustainability within Sierra Leonean Health Service to improve resilience to future outbreaks of Viral Haemorrhagic Fever' project in Sierra Leone (D2.53), volunteers provide clinical care to patients as well as on the job training and mentoring, in comparison to the 'Scaling up Medical Equipment Management project' (D2.40) in Uganda, where the long term volunteers provide training to technicians and students (due in part to the nature of the project). (N.B. Concerns associated with volunteers engaging in clinical delivery are discussed below). Lastly, some volunteers are engaged purely as short or long term volunteers providing capacity building support and clinical expertise in a specific field, whereas other volunteers also take on a **project management or coordination role** within the partnership.

As discussed elsewhere, the large majority of HPS projects are embedded within longer term institutional partnerships. As a result, implementing (or managing) specific HPS project activities is often **only one aspect of a long term volunteer's assignment overseas**. Looking at it another way, organisational inputs from the UK partner to the overseas partner in almost all cases include provision of support by volunteers visiting in-country, but the partnership goes well beyond this to also include support with training materials and curriculum, protocol and policy drafting, systems or strategy support and equipment donation. The graph below demonstrates the different organisational inputs provided to the overseas organisation through the partnership, as viewed from the perspective of the UK partner:

Figure 18: organisational inputs to overseas organisation through the partnership



4.3.2 Attributes of volunteers:

Personal and professional attributes

From all data reviewed, a clear picture emerges of the attributes – knowledge, skills and personal qualities - that are experienced and valued in a "successful HPS volunteer":

- Relevant clinical/technical skills and experience
- Leadership skills and mentorship
- Teaching skills
- Used to or capable of working using a collaborative approach – which may be a new way of working for overseas institutions. An approach which uses facilitation rather being than directive: *"It is important that volunteers come with a plan to work with others and make a contribution to the existing system, rather than with a view to change things"* (Health facility worker, Uganda).
- Enthusiasm and respect
- Strong volunteering ethos and personal drive/motivation; passion
- A can-do attitude and motivation; creativity and innovation; and capability to approach problems in different ways: "*We try to bring the paediatricians a finished product rather than a problem or just an idea – we think it through and do some research before bringing it to the head paediatrician or other consultants".* (HPS volunteer, D35, Myanmar)
- Cultural awareness and sensitivity; open mindedness
- Flexibility and adaptability; willingness to learn and adapt to local culture and low resource settings. In many cases, previous overseas experience in a similarly under-resourced setting was cited as an important volunteer attribute
- Strong interpersonal skills and an ability to build trust and lasting relationships
- A focus on systemic changes – e.g. systematic inputs in terms of developing standards and accreditation*: "Volunteer inputs included standards and module development (being) enhanced for nursing and midwifery mentorship"* (Volunteer survey).

Volunteers are frequently cited as being seen as **role models or leaders in their professional fields**. For example: "*I did act as a role model. I was invited to give a lecture at XX conference last week and I was the only woman speaker. Afterwards several of the lady doctors came up to me and said they were proud to see a lady speaking and it gave them confidence to do the same".* (F11, Nigeria Sheffield remote case study, LT volunteer).

Diaspora volunteers

There are currently or have historically been HPS diaspora volunteers from a range of countries, including Myanmar, Uganda, India, Zimbabwe, Uganda, Nigeria and Ghana. Of the 113 survey respondents from the volunteer survey, 11% were diaspora volunteers from the host country.

The visit to the medical equipment management project (D2.40) in Uganda highlighted the specific added value of diaspora volunteers in this context, where volunteers were able to understand the health system, the system blockages, the language and customs, enabling them to build up relationships and be effective from an early stage in their placement. "*Being a diaspora volunteer is part of our commitment, it gives us an opportunity to deal with "our own problems".* (Uganda diaspora volunteer). Similarly, one HPS project in Northern Nigeria found that having diaspora volunteers was considered hugely beneficial to the effectiveness of project - they were found to know the culture & language, local health system context and were well received. However, it should be noted there is no counterfactual to this analysis, and indeed our review of external literature on partnerships and volunteering (outside of HPS) suggests there is no clear evidence that diaspora volunteers are more likely to be more effective than other volunteers. Interestingly, one HPS project in Myanmar (A18) suggested the opposite to the findings in Uganda and Nigeria – that in this cultural environment, Burmese staff look up to foreigners - so being from the diaspora community was not necessarily viewed as a positive factor. However the two Burmese diaspora volunteers in Myanmar both recognised that their language and cultural knowledge also gave them a big advantage in communicating with a wide range of health staff and patients. This suggests that the **added value of diaspora volunteers may be specific to the context** in which the partnership is operating.

Approaches used by UK volunteers

The in-country and remote country case studies and overseas partner survey demonstrated that for many overseas health workers or educationalists, the particular approach used or nature of support provided by UK

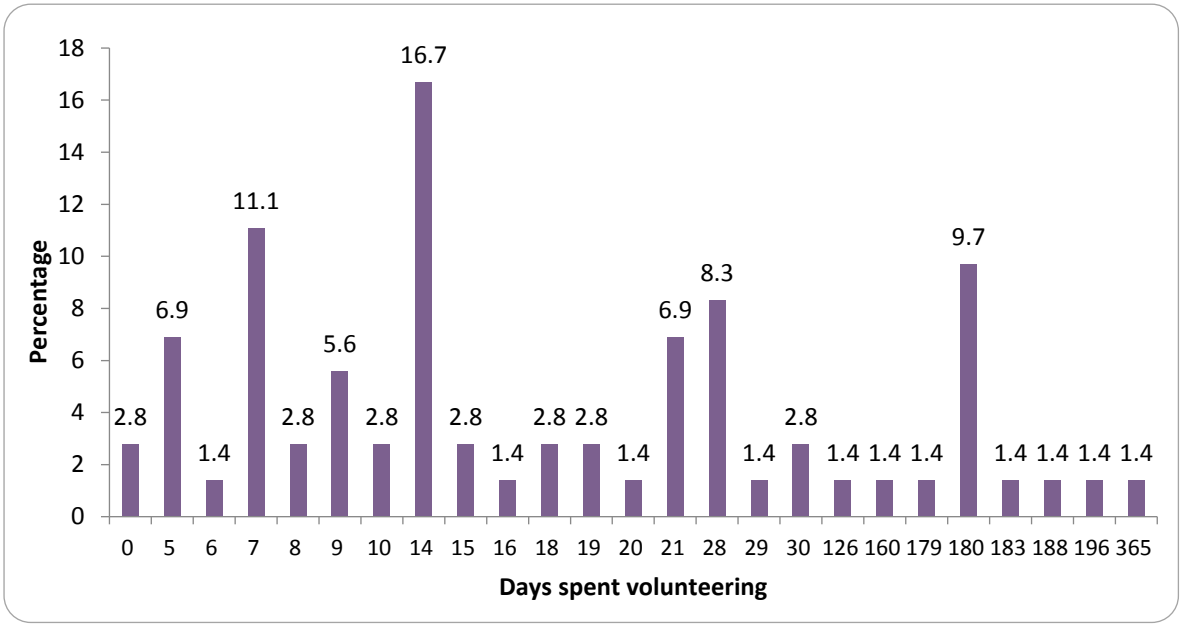
volunteers is what differentiates the training provided through the HPS. HPS volunteers tended to use practical teaching methods and interactive demonstrations, often considered more dynamic than the more traditional 'rote learning' approach that health workers in-country may have been exposed to. Secondly, the use of ongoing/in-service mentoring and support, as opposed to simply one-off teaching, is considered a critical supporting factor; training without follow up is considered less effective: *"It's a learning process, empowering and better than sitting in class"* (Overseas partner coordinator, Uganda, on mentorship). This finding is corroborated in Ackers and Ackers-Johnson's recent publication (Ackers, 2016): (NOTE: Not yet in press; embargoed until published) *"post-training mentoring is critical to knowledge mobilisation".* These approaches appear to not only strengthen the effectiveness of these workforce strengthening efforts, but also provide a longer term, knock-on effect in-country with regards to how further teaching or training is facilitated: "*This has impacted on my teaching. We now use role plays and other interactive methods of teaching."* (Health Education Institution faculty member, LPIP 56, Sierra Leone). Where volunteers are providing training of trainers, sustainability is already built into the approach, also contributing to longer term effectiveness.

4.5.4 Volunteer placements – attributes and management:

Length of placement

In our volunteer survey, of the 72 volunteers who responded to the question around days spent overseas during their last HPS volunteering assignment, the largest proportion (17%) spent 14 days volunteering overseas, 11% spent 7 days and 10% spent 180 days overseas. This provides a sense of the length of placements typically undertaken by HPS volunteers. In the sample of respondents, a total of 3,486 days were spent volunteering overseas.

Figure 19: Days spent overseas during last HPS-funded volunteering assignment (weekends included)



Across all data collected during the evaluation, there was an overwhelming preference for long term volunteering from the perspective of the host partner and project. The benefits over short term placements included:

- Allows volunteers to understand the contextual realities and challenges, and sufficient time to develop relationships with key stakeholders
- Allows for on the job supervision after training and ongoing mentoring (all LT volunteering that involved training)
- Enables partnerships to develop common knowledge and trust and allows for greater project flexibility
- Enables partnerships to make longer term and more systemic and sustainable changes (E.g. Equipment project Uganda)
- Enables partnerships to be more strategic in their nature and focus
- Helps with data collection – including for baselines and monitoring, especially in contexts where the data is not available (e.g. Emergency Paediatric care project in Myanmar)

The importance and value of longer term placements is demonstrated by the following statement: *"To generate changes in attitudes and behaviours, an ongoing presence, hand-in-hand work and on the job mentoring are required".* (Project coordinator, remote case study, DRC)

This preference for long term volunteering is often closely linked to the length of the partnership. It is important that the volunteer can build on the existing relationship that is established through the long term partnership – in these situations the volunteer is often "*better able to hit the ground running*" (returned volunteer). Thus the length of the existing partnership often appears to contribute or correlate with the success of placements – partners are able to manage each other's expectations and adjust. However, this is not always the case – for example, the RCPCH's wealth of experience in setting up emergency paediatric care projects means that short term volunteers are often able to 'hit the ground running.' It seems that the nature of the partnership itself is one way in which the support from volunteers is considered more effective than other types of technical support often provided through partnership working: "*The long-term relationships we have built up over the years with our colleagues from XX ensure mutual trust and respect so constructive criticisms can be offered and welcomed in both directions. This had led to a more mature understanding of the real challenges and issues and a shared partnership approach to moving forward*". (Overseas partner survey).

Short term placements were, on the whole, found to be less effective. For example, learning from some of the early HPS Multi Country Partnerships demonstrated that short term visits without clear objectives and strong management and support in country were not considered wholly effective. Interviews with returned short term volunteers highlighted the perception that limited change can be achieved through a short visit, unless there is a very specific focus to the visit. Barriers linked to short term volunteering include lack of deep knowledge of the local context and its challenges and lack of trust with partners. In addition, sending a series of different short term volunteers often means there is insufficient continuity, which makes it more difficult to build relationships and trust in the longer term. This point is also linked to the possible limitations of remote mentoring – we found some evidence (palliative care project, Uganda) to suggest that remote volunteers can find it difficult to provide remote support if they have never experienced the context and are unable to build up the necessary personal relationships in-country.

Volunteer placement attributes

Evidence also provides a clear picture of the types of volunteer placements which are more effective than others – in essence, the attributes which contribute towards a successful overseas posting. This section presents these findings:

- The extent that the host partner is involved in selection of volunteers. In the majority of projects, selection of volunteers is conducted primarily by the UK partner organisation, by the UK project coordinator. In some projects the host partner is more actively involved in volunteer selection, either through a project steering committee (e.g. palliative care project, Uganda) or with involvement of specific overseas partner staff (e.g. BCH project, Uganda). In these instances, the involvement of the host partner was viewed positively by project stakeholders – enabling competitive selection of quality volunteers, a good volunteer-placement match (in terms of expertise required), and contributing towards a more demand-driven approach. *"One of the differences is the team that normally comes to work with us – the process is evolving, we participate in interviews and even start working through what is expected of them, what the environment is like, and explore what their interests are, such that by the time they come they have an idea of what they want to achieve…"* (Key informant, Bwindi Community Hospital, Uganda). The findings suggest that placements should be driven by local needs and the strategic requirements of the partner – and not the expectations of the volunteer. This should however be balanced with an approach which also facilitates the volunteer getting strong added value through the placement, working towards their own professional objectives (as seen on the Improving Global Health through Leadership Development scheme).
- The level of preparation and pre-visit support which the volunteer receives appears to correlate with the UK partner and volunteer's perception of how successful their placement was. This was particularly the case for short term volunteering placements, where strong pre-departure support impacts how quickly and efficiently a volunteer is able to 'hit the ground running'. Elements of quality preparation included provision of handbooks and pre-placement meetings with UK project coordinators and past volunteers. Pre-departure support was considered important for volunteers who would otherwise have limited knowledge of the project or wider aid context.
- Level of induction on arrival and support during placement. Level of induction varies across HPS placements – with some projects demonstrating little or no induction and others citing a structured and

well managed induction (e.g. Nanyuki-Nyahururu-Torbay Partnership, Kenya; RCPCH Global Links Volunteer Programme). In Myanmar the five RCPCH volunteers spent two weeks in the Mandalay teaching hospital, which really helped them to understand the system, to make a network of contacts with the Mandalay paediatricians, to understand referral systems and build relationships with the MPS lead before they were deployed to the township hospitals.
    - A few volunteers highlighted the value in sending more than 1 international volunteer at a time, to be able to provide support and build up resilience.
- Clear roles and responsibilities for volunteers, which are outlined from the outset, was another crucial attribute of a well-managed volunteer placement. Particularly in the case of short term visits and where the overseas partner institute is involved in a number of partnerships (e.g. Kisiizi hospital, Uganda; Kings College, Sierra Leone), well-coordinated visits whereby the placement is able to feed into the strategic aims of the particular HPS partnership is important.
- Level of administrative support provided: as noted above, volunteers sometimes play a project management role themselves, with little or no administrative support provided (e.g. Addenbrooks, Myanmar). Other volunteers have administrative support provided, for example, to help them organise training sessions etc. The in-country project lead/coordinator often provides a vital link between the volunteer and local health system, so it is important that this person is fully supportive of the partnership (this was not the case with one partnership in Myanmar, negatively impacting on the project).

There are also a number of important attributes from the UK partner perspective which contribute towards successful volunteering overseas. Firstly, that the employer facilitates the volunteering placement e.g. is supportive institutionally, provides flexible study leave, or continues to make pension contributions whilst the volunteer is overseas. Linked to this, some UK partners expected their volunteers to conduct presentations etc. post placement in order to share their learning – and in this way were perceived as being supportive. Others were less supportive of placements, for example, one volunteer (Nigeria Sheffield project) reported having to resign from their post as their employer did not approve a sabbatical. Secondly, that the placement is conducted within a CPD framework – where there is formal recognition of the placement in the UK, this tends to facilitate volunteering. Some UK organisations appear to do CPD better than others, for example, the Royal Colleges have a requirement for accreditation of international project work for CPD and revalidation (HEE Toolkit paper). Similarly, those on the IGH Leadership Development scheme highlighted the focus of the scheme as "bringing back Quality Improvement back to the NHS" - an example of the importance of highlighting the UK systems impact. It is also important to ensure a systematic feedback mechanism is in place upon completion of the volunteer assignment, so that learning can inform future placements. The feedback may also be used to feed into the performance appraisal of the volunteer.

Lastly, remuneration to volunteers seems to vary across HPS partnerships – determined or set by the partnership itself. In some cases, volunteers report needing to invest some of their own money e.g. to pay for medical council registration. Remuneration of volunteers on HPS also differs to how volunteers are remunerated on other partnership programmes. For example, VSO and the Norwegian ESTHER programmes both pay their volunteers a salary. This could be an alternative approach for the HPS in future.

4.5.5 Impact of volunteering:

Professional and personal development of volunteers

The evidence of impact of volunteering on the volunteer at the individual level can be broadly categorised into the following areas: impact on soft skills, impact on hard/technical skills and potential impact on future employment prospects. This evidence is sourced from the majority of data collected – from interviews with existing and returned volunteers, with the UK partner, THET, the host partner and other international volunteering programmes, and through our online surveys and country case studies.

Soft skills and attitudes:

- Improved leadership, facilitation and managerial skills.
- Changed attitude – feeling more grateful for the NHS and greater appreciation for the working environment.
- Increased confidence and assertiveness
- Ability to take a more 'practical' approach in their work – to think outside the box, innovate in different circumstances and problem solve. Improved resilience
- Increased experience of multidisciplinary working and collaborative approaches to work

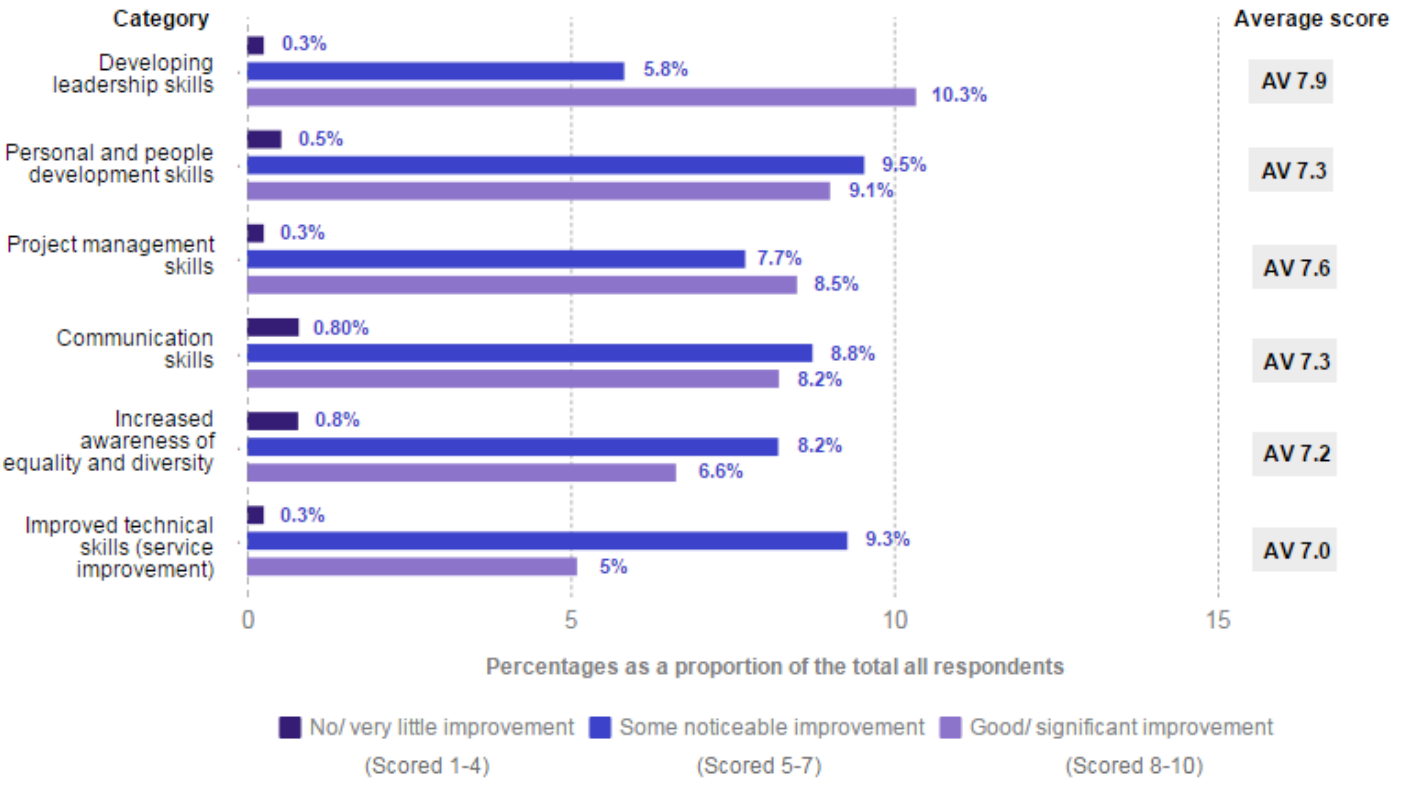
- International exposure, greater cross-cultural awareness and a better understanding of patients from different cultures
- An increased understanding of global health, and a wider view of health care, including how it fits into a broader public health approach. For example: *"Volunteering brought me a wider outlook on health - increased engagement with public and holistic health."* (Returned volunteer, survey respondent)

Hard/technical skills:

- Improved technical or clinical skills in specific fields; improved skills in how to deliver a quality improvement programme
- Experience of and improved knowledge and skills in new clinical fields (e.g. tropical disease) which health workers might not otherwise see in the UK
- Improved teaching skills: "*Since the course I have become involved in teaching in my own place of work and plan to develop and deliver teaching sessions"* (volunteer survey respondent)
- Project management/budgeting/M&E/financial management – skill areas which a UK health professional may not have experienced. This was often cited as a positive example of how their skillset had broadened: *"A new skill that will particularly be of service in my future career is learning how to plan and structure a project that lasts over a significant period of time".* (Volunteer survey respondent)

The above findings are triangulated with the quantitative figures from the voluntary survey. The large majority of survey respondents (93%) felt they had benefited from their volunteering experience with HPS (n=76). The graph below demonstrates the specific skill areas which volunteers felt they had developed whilst volunteering overseas. Leadership skills and personal and people development skills were rated most highly – in terms of the proportion of respondents who felt they had seen a significant improvement in these skill areas.

Figure 20: Skill areas of improvement for volunteers



One respondent in the volunteer survey summed their experience up by: *"Skills – teaching, training, mentoring clinical work and running projects, managing people and funding. Experience - different ways of working and dealing with people, appreciation of different culture. Knowledge - vast increase in clinical skills as honed these whilst less technology available."* (Volunteer survey respondent).

The above developments in personal and professional skills resonate with findings from other similar partnership programmes, such as the Improving Global Health Leadership Development Scheme and the ESTHER programme.

Potential for future employment benefits:

There was mixed evidence for this:

- A number of volunteers, particularly long term volunteers, cited improved employment prospects – building a more impressive CV, and experience of leadership perhaps earlier than would have got in UK. For example: *"Invaluable experience to develop leadership skills, learn about my own competencies and self-development to realise areas of difficulty and why they occurred. I learnt a lot about the NHS and why our systems may have developed as they have and also I learned how similar human behaviour is across cultures/borders, which I believe is a strong realisation to help me in any future roles of leadership and how to influence for positive change."* (Volunteer survey respondent)
- One volunteer in Uganda has been strategically positioning himself e.g. by presenting at conferences and mentoring UK students, so that he is more employable back in the UK.
- However, the above findings were by no means conclusive, and in a number of instances of short term volunteering in particular, UK volunteers did not feel that the placement had a real or tangible impact on their career or employment prospects in the longer term.

Impact on UK health system – at institutional level:

One objective of the HPS is to generate 2-way learning and UK health system impact. From the body of data collected, there is some evidence of positive impact of overseas volunteering on the UK health system. Almost all the skill areas mentioned above at the individual level are transferable skills – be it collaborative working, a broader view of health care, adaptability, leadership skills and maturity, or hard clinical skills – and a number of interviews, case studies and the online surveys, demonstrated (anecdotally) that these skills are brought back to the UK institution. As an example, one respondent in the UK partner survey stated that their volunteers brought back: "*A broadening of minds in the staff concerned, particularly with regards to the concept of equity in provision of health care and, a stimulus towards being able to achieve more with less"* (UK partner survey respondent). As noted above, there were numerous examples where greater interest and strengthened capacity in leadership and management at the individual level occurs earlier than what might have happened within the UK – so volunteers are effectively being 'fast tracked' whilst overseas - and can then apply these skills and knowledge back in the UK.

In a large number of HPS projects, the UK partner cited increased visibility of their organisation in the international arena as a key institutional benefit. Placing staff overseas was seen as a way to raise the profile and reputation of the UK organisation as a potential provider of global health programmes, and their involvement in the HPS had facilitated wider networking opportunities and relationship building with other health institutions or donors. Participation in HPS was seen to benefit the development of new academic, clinical or research links with other institutions in the global health community. Although hard to quantify, this informal interchange of ideas – at the institutional level - is a clear UK health system benefit and also demonstrates the promotion of the NHS abroad. These findings are illustrated by the following quotes:

- "*Our global work is now a priority across the whole organisation which it was not before. The publications from the project have bought us credibility."* (UK partner survey respondent).
- *"It has increased our reputation and others' confidence in us as a provider of global health programmes. It has enabled us to network more widely and to give many conference presentations, thus getting exposure to new fields. It has strengthened our relationship with DFID and other donors. It has strengthened our links with both UK schools of tropical medicine - as programme director I am now on a programme board for LSTM. Our global work is now a priority across the whole organisation which it was not before."* (UK partner survey respondent)

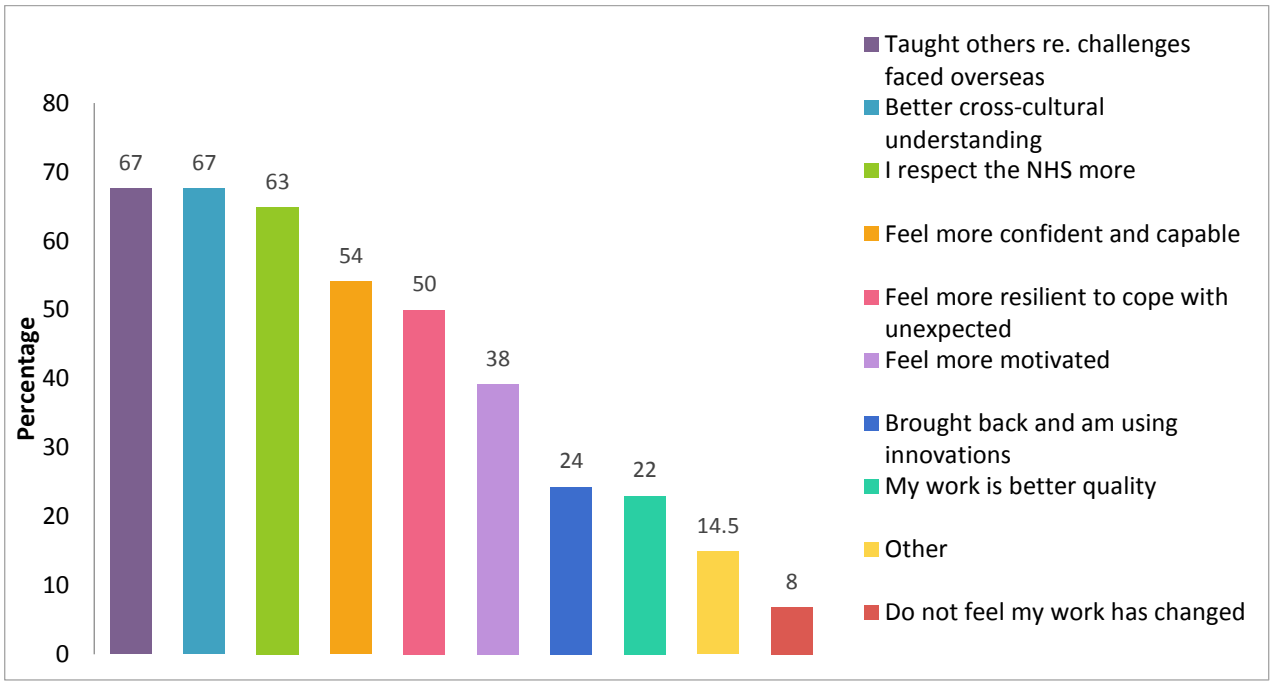
There were also a significant number of volunteers and partners who cited being increasingly motivated and 'reenergised' through their volunteering placement overseas. In some instances, the experience with HPS generated renewed respect for the NHS amongst UK volunteers and staff. Volunteering through the HPS provided staff development opportunities – and this may potentially impact NHS staff retention. These findings are illustrated in the following quotes:

- *"It is stimulating to work in a different environment from time to time, puts things into context. I have the ability to do more with less now."* (UK returned volunteer interview)

- *"I suppose anything benefits you if you reflect or learn from it… but whether the actual experience there benefited me…not particularly no. But the value for individuals relates to when people get jaded in their work and need to get some perspective. It's about personal motivation".* (UK returned volunteer interview).

Many of these findings are validated through the quantitative figures in the volunteer survey. On their return from their overseas volunteering experience, respondents cited a wide range of benefits to their work in the UK. More than two-thirds (67%) of respondents stated that they had taught others in their organisation about the challenges that health workers face overseas, and that they had better cross-cultural understanding. 63% stated that they respected the NHS more and 54% felt more confident and capable in their jobs as a result. 24% felt that they had brought back innovations which they were now using in their work in the UK. Only 8% (n=6) felt that their work in the UK had not changed as a result of their volunteering experience (4 of the 6 were aged over 41 years). This is demonstrated by the graph below:

Figure 21: Benefits to work of Volunteers on return from overseas



The findings also suggest that overseas volunteering could help to address some of the current challenges in retention (or even future recruitment) of specific cadres within the UK health system. For example, the Uganda case study suggested that one of the benefits for the Royal College of GPs in participating in the HPS, is the incentive that a 6-month volunteering assignment overseas offers.

There were some but limited examples in the data collected, of volunteering overseas changing teaching materials or practice within the UK. Some examples include: use of specific behaviour change techniques within UK based teaching (volunteer survey), use of examples from Uganda in UK teaching materials (Project D.43, Uganda); introduction of specific materials, such as prescription sheets, that worked well overseas (oncology project, Uganda, Uganda workshop).

4.5.6 Challenges & risks of using volunteers

Challenges and draw backs in-country:

This section outlines some of the challenges faced by UK volunteers when in-country, as well as the challenges and risks (for overseas partners) of using international volunteers in this context. Common challenges experienced by volunteers included:

- Language issues - particularly around training, where the meaning was often lost in translation
- Lack of cultural awareness/ knowledge of local system which created barriers with their counterparts and patients: "*They should know the culture of the local people. The system here is so different from the UK. They have to face the challenges patiently, encouraging the champions step by step"* (In country project lead, Myanmar)

- Stigma/discrimination (e.g. there were instances of young while female volunteers experiencing challenges in certain contexts)
- Challenges of 'per diem' culture and health worker attitudes towards training which volunteers may experience when trying to organise training
- An expectation (from overseas counterparts) that volunteers should work in direct clinical service delivery i.e. labour substitution, as opposed to in capacity strengthening related activities (which is the key focus of the HPS).

Of note: our review of external literature on volunteering validates the above concerns regarding labour substitution and the negative impact this can have. The "iDSI health systems strengthening" paper (Baxi 2015) confirms that the volunteering model can promote provider level activity rather than systems level change, and suggests that to address this, strong leadership and required 'co-presence' is necessary (for accountability purposes) when deploying professional volunteers overseas. (Ackers, 2016) Recent draft publication similarly suggests that labour substitution can undermine health systems strengthening efforts.

There can also be challenges for the overseas partner institution in using international volunteers – and a number of risks which need to be managed. Firstly, there were instances (e.g. at BCH and Kisiizi Hospitals in Uganda) where several partnerships operated within the same institution, leading to potential "volunteer fatigue". One project worker also highlighted the importance of partnerships knowing when to step back and allow the overseas institution to rely on the local staff whose capacity had been strengthened, demonstrating there is probably a saturation point in terms of volunteer visits and their impact on generating systems change. Secondly, there were a small number of instances where the risks of using volunteers who may not be sufficiently qualified to deal with the cases they are presented with (do no harm principle) were cited. For example: "*The amount of responsibility the volunteers get is huge and they do a great job, but sometimes our doctors don't have the right training to make the difference they could make clinically."* (Project in Sierra Leone)

Drawbacks of using volunteers – challenges for the UK health system:

The evidence collected suggests that there can be significant drawbacks for the UK health system in sending professionals to volunteer overseas. The most commonly cited challenge by UK partners was having insufficient capacity to release staff to volunteer overseas and being able to manage their workload during staff absence. This was particularly the case for long term volunteering placements. Some UK organisations appeared better placed to do this than others – for example, the Royal College of Paediatrics and Child Health is well placed (as they have a large global volunteering programme in place, with wider funding, but also send volunteers at a particular point in their careers when they will be changing jobs anyway) as compared to NHS Trusts who may find it easier to fund short term opportunities only. This again demonstrates the need for volunteering to be 'systematised' within the organisation and the wider UK health system. There can also be challenges reintegrating staff after long term assignments, which also needs to be factored in by the UK partner. Lastly, there were a few instances within the data collected where volunteers chose not to return to their jobs within the NHS but instead remained working in the international sphere.

Another cost for the UK health system is volunteers' pension costs. The cost of covering these pension costs is £1,397 per volunteer per year – currently these costs are paid for by the HPS. There are plans currently being developed for these costs to be covered by the NHS as part of professional development.

Lastly, there are the potentially 'hidden' costs for UK partners' involvement in the HPS – including the administration and coordination/management that goes beyond what is covered in the HPS project budget. For example, the RCSEd reported spending around £45,000 of their own budget on their HPS project (including travel costs, consultancy costs, administration and management). Given that many UK partners are often unfamiliar with managing overseas projects, there is also a learning curve to take into account, which may translate to a tangible cost to the UK partner, or THET as the fund manager

Annex 5: Health Partnership Scheme Evaluation Terms of Reference

This terms of reference was updated during the inception period with the revised purpose, audiences and evaluation questions. The rest of the TOR remains the same

4.1 Introduction

DFID's Health Services Team is seeking to commission an evaluation of the Health Partnership Scheme (HPS) implemented by the Tropical Health and Education Trust (THET). The HPS supports partnerships between UK health institutions and those in low income countries. The Scheme uses the expertise of UK health professionals and institutions to build capacity of their counterparts in developing countries and is also intended to bring back benefits to UK institutions, with NHS volunteers returning with enhanced skills, motivation and confidence. Since it began in 2011, over 1,000 NHS health workers have volunteered with projects across 26 countries in Africa and Asia.

The first independent evaluation of the programme is due to start last quarter 2015. The evaluation will contribute to DFID's oversight of this programme and also contribute to strengthen and adjust approaches that THET is deploying in this programme as necessary. In addition, the evaluation is also intended to contribute to better understanding, decision-making and design of health partnerships through the identification of best practice and other lessons learned.

4.2 Purpose and Objectives

The ***purpose of this evaluation*** is to examine the health partnership model that has been implemented in the HPS programme. The focus is on the effectiveness of the programme as a whole, plus learning about what works and what does not work in the current programme's approach. The evaluation will inform wider lesson learning about volunteering and building health worker capacity in developing countries, and reciprocal benefits of partnerships, and associated volunteering, in the UK. The evaluation will provide evidence of the effectiveness of HPS as a whole, as well as progress towards outcomes and, if possible to assess, impacts. It will recommend how to strengthen the programme M&E, based on the conclusions of the evaluation. This will contribute to robust monitoring in the remaining programme implementation and for possible future partnership programmes.

- *Primary evaluation audiences*: DFID, THET, other UK Government Departments (including NHS Improvement and Department of Health), the non-state sector (e.g. International Academy of Medical Royal Colleges) and developing country government institutions and other HPS health partners in the south.
- *Secondary evaluation audiences*: Organisations involved in health partnerships, other development partners (bi-laterals and the WHO), developing country governments, civil society and practitioners who are working on the improvement of health systems.
- Learning will be used by stakeholders in the design of future work and future evaluations.

The current HPS programme Theory of Change provides a conceptual framework of the intervention logic, and states assumptions about the 'logical progression from inputs to impact on health'21.

Learning - The evaluation will describe key ways the HPS model has or has not evolved in three years of implementation and adaptation, and whether this has been consistent with the intervention logic.

21 DFID Project Memorandum, DFID Health Partnership Scheme, November 2010, p.28.

Future programming - The evaluation will critically appraise the HPS theory of change and the assumptions it makes. The **evaluation questions** to be answered are below. These will be further refined during the inception stage.

1. To what extent and under what circumstances is the HPS programme achieving its stated outcome: "more effective and efficient health systems, with an emphasis on the performance of the health workforce" and is there any evidence of impact? (DAC Criteria: Effectiveness, Impact and Equity). This should include the benefit to both developing country and UK health workers and institutions.

What has happened and how?

- Who is benefitting - systems, practitioners, service users? Is the reach equitable – e.g. men and women, those who are underserved, very poor and those living in rural areas, health workers and service users?
- What are the benefits being realised – with particular focus on outcome and impact indicators specified in the log frame , and health services related to MDGs 4, 5, 6?

2. Is the programme delivering value for money? (DAC Criteria: Effectiveness, Efficiency, Equity, plus VfM criteria of Economy)

- Are some types of partnerships (or features of them) better VfM than others, in terms of economy, efficiency, effectiveness or equity
- Is THET's management of the programme supporting VFM work by the funded health partnerships?

3. What lessons can be learned in relation to strengthening partnerships between UK and developing countries' health institutions, the partnership use of volunteers from the UK to deliver projects and the effect of this on project effectiveness (to deliver stronger health systems and build capacity of the workforce)? (DAC Criteria: Relevance, Efficiency and Effectiveness)

- What types of partnership have been most successful and which have been most challenging?
- What form have the partnerships taken (a descriptive typology22 -- who, what, when, how long, special features)?
- What worked and what did not in terms of achieving improvements in health systems?
- Are there examples of partnerships overlapping, aligning or reinforcing each other?
- Is the programme building social capital for global health work, and is this contributing to outcome and impact?

4. To what extent have the HPS projects been identified, designed and delivered in response to the host country context and in alignment with government plans and strategies? (DAC Criteria: Relevance and Sustainability)

5. How has HPS benefited the UK in terms of strengthening the health workforce, health systems and/or in terms of recruitment and retention of health workers? (DAC Criteria: Effectiveness, Sustainability and Equity)

6. How can the HPS (programme, projects and partnerships) be monitored and evaluated?

- How can future M&E include impact as well as outcomes and VFM?
- What approach is recommended for aggregating data from numerous, diverse health partnerships, and for drawing conclusions at the programme level?
- What is a realistic level of detail and investment for M&E in this programme?
- What VfM metrics and analyses are suitable to monitor the programme?
- What VfM metrics and analyses are suitable to monitor individual health partnerships?

22 THET has separately commissioned operational research that is also developing a typology of partnerships. This is is a lengthier and more detailed undertaking than the evaluation is expected to deliver. The evaluator is encouraged to draw upon this work, keeping the typology for the evaluation to 2-3 pages, and to use it as a main criteria and reference for selecting sites to visit.

The contracted management agent has been expected to have a commitment to gender equity in all its operations, with particular attention to gender roles and sensitivities in diverse cultural settings, whilst ensuring that partnerships promote gender-based rights. In addition to equitable access to gender-sensitive and appropriate health services, there is the gender dimension to health worker career options and career trajectories in developing countries (eg, women trained as nurses, men as doctors, men progressing to more senior, better-paid managerial and leadership roles).

4.3 Recipient

The recipient of this work is the programme participants and health service users.

The evaluation deliverables will be provided to DFID and the implementing partner THET.

Relevant communications will need to be developed for each of these audiences as part of the communication and learning strategy of evaluations (responsibility of DFID and THET).

4.4 Scope

This evaluation will cover the duration of the HPS programme, which has been operational since 2011. It is expected that the evaluation will start last quarter 2015.

The evaluation will visit several countries, and visit a range of sites and programmes that reflect the variety of HPS partnerships. However, the evaluation is not expected to visit all partnership sites. It is preferable that there is a gender balance in the evaluation team undertaking the qualitative work.

The evaluation will focus on the following target groups:

- Health workers directly involved in the programmes, including heath managers and educationalists from the UK and developing countries;
- Users of health facilities and services that have participated in the programme
- Implementing partner - THET

As relevant and when it is feasible, the evaluation will include:

- Administrators and other representatives of developing country partner organisation or associations (strategies, protocols, curricula)

The evaluation is expected to include:

- Review of relevant, current literature about health partnership programmes.
- Development and use of a descriptive typology of HPS partnerships (drawing on research that is currently being commissioned by THET).
- Assessment of outcomes and, when possible, the impact of the programme
- Gathering participant and beneficiary feedback, including constructive criticism
- Analysis of VFM using existing M&E data, and recommendations for possible VFM measures
- Producing recommendations for strengthening future M&E.

4.5 Methodology

Starting with a desk-based evaluability assessment, the evaluator would determine the specific methodology of the evaluation23. A theory-based approach is to be considered for this summative evaluation.

23 This timing is to inform the specific design of the evaluation that has been planned. It would examine evaluability in practice, that is, data availability to carry out the evaluation and the systems able to provide it, as well as the likely usefulness of an evaluation.

It is expected that a mixed methods design combining analysis of secondary data with the collection and analysis of primary quantitative and qualitative data will be appropriate to respond to the evaluation questions.

Quantitative data may be derived from a range of sources including but not limited to partner facility institutional records24, project monitoring records and surveys. Qualitative data may be derived from sources such as interviews, focus groups, and participant and non-participant observations.

The framework used to analyse both quantitative and qualitative data should be determined by the evaluator. It should be rigorous and sufficiently robust in order to identify changes that may be plausibly associated with the programme and that may contribute to the desired outcomes and impact.

The analytical framework should identify pathways through which these changes have and could happen.

The following data collection methods are encouraged:

- document review (HPS documents, partnership reports and monitoring)
- case studies
- focus groups discussions (FGDs) (of country participants, as appropriate)
- key informant interviews (KIIs) (of country participants and UK partners, as appropriate)

An outcome mapping/harvesting exercise in the FGDs and KIIs would be useful to explore what has happened and how those involved in the intervention think it contributed to observed change(s). The final assessment about the suitability of this methodology rests with the evaluator.

The project has reported positive feedback thus far but needs to ensure that both positive and constructive feedback is captured during monitoring and evaluation especially from developing country partners and recipients of training.

Detail any limitations likely to impact on the scope (e.g. geographical, political, administrative issues)

Geographical - Due to the Ebola epidemic in West Africa, evaluators will not be expected to visit some countries where Ebola is present.

Administrative - Some partnerships may have completed activities by the time of the fieldwork, while others may be in initial phases. Evaluators are encouraged to consider including them in the evaluation and site visits.

Travel - Will be limited by budget and logistical feasibility. It is desirable that evaluators conduct country visits, preferably to countries where they can visit more than one partnership to explore potential synergies, as well as efficiency.

Representativeness, ability to generalise - The HPS is a £30 million programme which includes a range of partnership sizes and intervention activities, operating in diverse social, political and health contexts. The evaluation will only be able to look at a relatively small portion of this work making generalisation difficult. This TOR also anticipates that the evidence of both outcomes and impacts will vary in strength across the programme. It expected that, using the descriptive typology that has been suggested, the evaluation will include a strategic selection that reflects the range of partnerships and activities. Nevertheless, drawing conclusions about the programme as a whole will be difficult.

Resources that will be available - The Evaluator will have access to THET programme monitoring data and subsequent analysis.

Data about health workers involved in the projects is disaggregated by gender and cadre; data about health services and health systems strengthening is disaggregated by health theme and level of healthcare; data

24 These are a source of verification in the programme logframe.

about health institutions is disaggregated by population served; data about patients is disaggregated by gender.

Once the evaluator has identified their preferred partnerships and sites to visit, THET will introduce them to the relevant UK partners, who will liaise / put them in touch with their overseas partners, to agree visit dates, schedules and in-country support. Support may include facilitating meetings and providing or booking transport and accommodation, but this will depend on the resources of the specific partners visited.

Who will be responsible for compiling initial documentation?:

THET will prepare programme documentation for the Evaluator. The suitable documentation will be discussed and agreed with DFID's Health Services Team and the Evaluation Steering Group.

4.6 Ethics

The evaluator will be expected to adhere to the DFID Ethics Principles for Research and Evaluation. This will include but not be limited to the following:

Information about specific partnerships and MOUs will be treated confidentially.

Individual respondents (NHS volunteers, country health workers and health service uses) will be informed of the purpose of the research and have the option to voluntarily participate in the evaluation.

Evaluation code of conduct:

The evaluation of DFID assistance is guided by the core principles of independence, transparency, quality, utility and ethics. The evaluator will be expected to work according to these principles25.

4.7 Fieldwork

The evaluator is encouraged to gather data directly from programme partners and beneficiaries, including observing the institutions.

4.8 Governance arrangements

The evaluation will be managed by DFID's Health Services Team.

There will also be guidance from a Steering Group including internal (DFID) and external stakeholders. The purpose of the Steering Group will be to guide the design of the evaluation and quality assure the evaluation outputs. The group's input should ensure that the evaluation has credibility across the range of stakeholders.

Inception, work-planning and review meetings

Meetings with evaluators and the steering group will take place as required to ensure that the provider has all the necessary advice and guidance they require and that key stakeholders are satisfied with the work being done.

Commenting on study outputs (including timescales)

DFID leads will provide comment on all study outputs (see below). The Steering Group will be invited to comment on the evaluation workplan and inception report (at month 1 or 2), the interim progress report (months 3-4) and the final report.

THET/partner organisations will be invited to comment on all study outputs and will provide feedback within 2 weeks.

25 See DFID Evaluation Policy 2013, pp6-7.

Quality assurance of study outputs (including timescales)

Quality assurance will be conducted, in accordance with DFID evaluation policies:

DFID evaluations are QA'd at 'entry' and 'exit'. Entry QA is of the two outputs - the evaluation TOR (this document) and the evaluation design including data collection protocols/instruments. Exit QA - evaluation final draft report.

Quality Assurance is currently conducted by SEQAS, a contracted service. There is a 10 working day turnaround, provided that the programme team is able to notify them in advance about the delivery of the outputs.

4.9 Requirements

The evaluation provider will be commissioned through a competitive tendering process/using DFID evaluation frameworks.

The following capacities are required/desirable:

- Experience in conducting assessments and evaluations of health sector development programs, with emphasis on developing health worker and institutional capacity, in developing countries.
- Knowledge of partnership-based approaches to developments, including the concept of social capital.
- Knowledge of good practice and literature about developing health worker and institutional capacity, in developing countries.
- Experience constructively critiquing and developing log frames and theories of change.
- Experience in primary qualitative and quantitative data collection and analysis.
- Strong analytical skills and ability to think strategically and concisely analyse and integrate information from a diverse range of sources into practical and realistic recommendations.
- Effective communication skills, written and spoken, in English required.

The successful provider will coordinate and work closely with the implementers of the HPS to ensure the full utilisation of technical outputs of this programme, to contribute to project course correction where relevant, and to work towards closing gaps in evidence, both nationally and internationally.

4.10 Outputs

Month 1: Evaluation workplan and outlining data collection instruments, and relevant ethics procedures that will be used - (to be reviewed and approved by Steering Committee)

Month 1 - 2: Inception report covering a desk-based evaluability assessment and that outlines evaluation options, with their strengths and limitations, concluding with recommendations for evaluation approach.

Month 2: (ideally) Literature review and descriptive typology of partnerships (who, what, when, how long, special features)

Month 2: (ideally) Evaluation methodology, supported by the literature review, with data collection instruments, including sampling based on partnership typology, analysis plan, coding framework for primary data (surveys, interviews, focus groups), and reporting/dissemination plan (to be QA'd following DFID Evaluation policies)

Month 3 - 4: Progress report (1-2 pages) referring to workplan.

Month 5 - 6: Draft final report (to be QA'd following DFID Evaluation policies) with updated theory of change, lessons learned and recommendations.

Month 7 - 8: Final report, incorporating Steering Group comments, and, upon completion, primary data cleaned, labelled and with identifying information removed.

Constraints and Dependencies (if any exist)

Timing considerations (e.g. cannot start before, or must be complete by)

The evaluation will start last quarter of 2015. The duration is expected to be approximately six months from start to submission of first draft of final report and eight months to final completion of all requirements.

Interwork with other suppliers:

It is not expected that the evaluator will need to work with other evaluation or M&E suppliers. The evaluator will be expected to engage closely with the implementing partner THET and grant-holders.

Interface with other organisations' IT systems:

The evaluator will have access to THET programme monitoring databases and the data contained in them.

Stakeholder/recipient schedules and availability:

The evaluator will have to plan field trips in collaboration with THET and grant-holders to ensure that the scheduling is appropriate for all parties.

Management of risks/challenges:

The evaluator will perform appropriate risks assessments for the project including field visits. THET will provide information on risks and risk management at country level as requested by the evaluator.

4.11 Timeframe

This contract will commence late 2015, with the final report completed (including QA) within 8 months. No extension is anticipated, but there will be an option to extend for 3 months.

4.12 DFID Co-ordination

The following people will support the development of this evaluation and its requirements: Policy Division Health Services Team Programme Manager, Health Adviser, and Economic Advisor.

4.13 Background

The Health Partnerships Scheme is a £30 million programme linking health institutions in the UK with counterparts in developing countries. The programme, which began in 2011, aims to use the expertise of UK health professionals to build human resources for health in DFID priority countries. It works across more than 20 countries.

The Health Partnership Scheme (HPS) supports partnerships between UK health institutions and those in low income countries**. Its aims are:**

- Improving health services in developing countries through sharing skills and capacity development
- Bringing benefits back to the UK through volunteer NHS staff returning with stronger skills

The scheme has two main components: a grant for partnership projects, as well as activities to support and develop the health partnership community in the UK and overseas.

The original grant provided £20 million over 4 years (July 2011 – June 2015) but was extended until 2017 with a further £10 million of funding announced in 2014.

The project enables a wide variety of projects ranging from individual mentoring and training of clinical workers to developing systems of training and strengthening professional associations.

The project's results have consistently exceeded expectations. In the first two years the project took time to get established and to award grants. After grants were awarded, it took time for partnerships to establish themselves. In its third year, the programme shifted away from start-up and grant awarding activities and into the core business of partnership activity and advocacy. The groundwork laid in previous years had come to fruition in the third year, and the momentum that had been built up in previous years yielded very high results.

Since the inception of the programme, the HPS has delivered training (directly or indirectly) to over 26,500 health workers in the developing countries and over 84% (~22,000) of these training results were achieved in the third year. Partnerships have also continued to show strong performance in the development of policies, protocols and educational curricula. They have also made strong contributions to improving equipment and ICT within institutions, often going beyond their original project plans to the improve systems necessary for health care.

In 2014/15 many projects are winding down, as many grants expire in March 2015. The time taken for partnerships to build their work up to full capacity is a lesson which can be applied in setting milestones for the extension period.

In April 2014 an extension of HPS was announced providing another £10 million to extend the programme to 2017. This extension will include a new round of grants to be awarded in the next year and should enable many of the best-performing partnerships to continue as well as allowing others to scale-up or establish new partnerships.

Detail on existing key initiatives and studies within the area

2013: VFM assessment of the International Health Links Funding Scheme (precursor to the HPS)

2014: HLSP conducted a mid-term review of the HPS 'mega-grants' (Multi-Country Partnerships and Long Term Volunteering grants) examining them against Development Assistant Committee and value for money criteria.

2015 (commissioned): How the health partnership approach contributes to the delivery of programme outcomes: phase 1 of a research project (TORs available).

2015 (commissioned): 2–3 case studies of health partnership value for money, for publication by THET; outline systems for more rigorous VFM monitoring (TORs available).

4.14 Duty of Care[26]

The Supplier is responsible for the safety and well-being of their Personnel (as defined in Section 2 of the Contract) and Third Parties affected by their activities under this contract, including appropriate security arrangements. They will also be responsible for the provision of suitable security arrangements for their domestic and business property.

DFID will share available information with the Supplier on security status and developments in-country where appropriate. DFID will provide the following if required:

All Supplier Personnel will be offered a security briefing by the British Embassy/DFID on arrival. All such Personnel must register with their respective Embassies to ensure that they are included in emergency procedures.

26 See Smart Guide_Procurement - http://insight/Smart-Rules/Documents/Smart Guide_Procurement.docx

A copy of the DFID visitor notes (and a further copy each time these are updated), which the Supplier may use to brief their Personnel on arrival.

The Supplier is responsible for ensuring appropriate safety and security briefings for all of their Personnel working under this contract and ensuring that their Personnel register and receive briefing as outlined above. Travel advice is also available on the FCO website and the Supplier must ensure they (and their Personnel) are up to date with the latest position.

This Procurement may require the Supplier to operate in a seismically active zone and is considered at high risk of earthquakes. Minor tremors are not uncommon. Earthquakes are impossible to predict and can result in major devastation and loss of life. There are several websites focusing on earthquakes, including http://geology.about.com/library/bl/maps/blworldindex.htm.

The Supplier should be comfortable working in such an environment and should be capable of deploying to any areas required within the region in order to deliver the Contract (subject to travel clearance being granted).]

This Procurement may require the Supplier to operate in conflict-affected areas and parts of it are highly insecure. Travel to many zones within the region will be subject to travel clearance from the UK government in advance. The security situation is volatile and subject to change at short notice. The Supplier should be comfortable working in such an environment and should be capable of deploying to any areas required within the region in order to deliver the Contract (subject to travel clearance being granted).

The Supplier is responsible for ensuring that appropriate arrangements, processes and procedures are in place for their Personnel, taking into account the environment they will be working in and the level of risk involved in delivery of the Contract (such as working in dangerous, fragile and hostile environments etc.). The Supplier must ensure their Personnel receive the required level of training and if required complete a UK government approved hostile environment training course (SAFE)27 or safety in the field training prior to deployment.

Tenderers must develop their Tender on the basis of being fully responsible for Duty of Care in line with the details provided above and the initial risk assessment matrix developed by DFID (see Appendix A of this ToR). They must confirm in their Tender that:

They fully accept responsibility for Security and Duty of Care.

They understand the potential risks and have the knowledge and experience to develop an effective risk plan.

They have the capability to manage their Duty of Care responsibilities throughout the life of the contract.

Acceptance of responsibility must be supported with evidence of capability (no more than [2] A4 pages and DFID reserves the right to clarify any aspect of this evidence. In providing evidence Tenderers should consider the following questions:

a) Have you completed an initial assessment of potential risks that demonstrates your knowledge and understanding, and are you satisfied that you understand the risk management implications (not solely relying on information provided by DFID)?

b) Have you prepared an outline plan that you consider appropriate to manage these risks at this stage (or will you do so if you are awarded the contract) and are you confident/comfortable that you can implement this effectively?

27 UK Government approved hostile environment training course is known as SAFE (Security Awareness in Fragile Environments). The course should be booked through DFID and factored into the commercial tender.

c) Have you ensured or will you ensure that your staff are appropriately trained (including specialist training where required) before they are deployed and will you ensure that on-going training is provided where necessary?

d) Have you an appropriate mechanism in place to monitor risk on a live / on-going basis (or will you put one in place if you are awarded the contract)?

e) Have you ensured or will you ensure that your staff are provided with and have access to suitable equipment and will you ensure that this is reviewed and provided on an on-going basis?

f) Have you appropriate systems in place to manage an emergency / incident if one arises?

Further information on Duty of Care is provided in the Supplier Instructions (Volume 1 of the Mini-Competition Invitation to Tender Pack).

4.15 Security

Security arrangements are described above and will depend on the selection of field visit sites.

Quality Standards/Performance Requirements: The evaluation of DFID assistance is guided by the core principles of independence, transparency, quality, utility and ethics. Quality pertains to personnel, process and product in evaluation. Independent quality assurance is mandatory during the 'entry' design phase and at the 'exit' (draft final report) stages. In addition to quality assurance requirements, a formal management response to all findings, conclusions and recommendations from an evaluation is required, and should be published with the evaluation.

The Evaluator's services and performance will be assessed using DAC Quality Evaluation Standards.

4.16 Budget

The budget for this evaluation is [£300,000] (excluding VAT) and it is expected to cover the costs of evaluation staff, primary data collection, secondary analysis, field visits, analysis and reporting.

ANNEXES

Attached is relevant documentation to inform the proposal that will be developed in response to this TOR:

- Project Memorandum
- Annual Review
- International Development Committee, Strengthening Health Systems in Developing Countries. Fifth Report of Session 2014-15
- Terms of Reference for steering groups overseeing the evaluation
- Ethics principles for evaluation and research
- Updated HPS logframe
- Available datasets to support the evaluation

Annex 6: Terms of Reference for HPS Evaluation Governing Groups

Background

The Health Partnership Scheme (HPS) is a £30 million DFID-funded programme implemented by the Tropical Health Education Trust (THET). An external evaluation of the programme is planned to run from February-October 2016. The ***purpose of this evaluation*** is to examine the health partnership model that has been implemented in the HPS programme. The focus is on the effectiveness of the programme as a whole, plus learning about what works and what does not work in the current programme's approach. The evaluation will inform wider lesson learning about volunteering and building health worker capacity in developing countries, and reciprocal benefits of partnerships, and associated volunteering, in the UK. The external evaluation will be managed by DFID's Health Services Team (Management Group), with guidance from a Reference Group (the Reference Group replaces the original Steering Group which advised on selecting an appropriate evaluation bid from the tender), and a Wider Stakeholder Group. The Reference and Stakeholder Groups will include internal (DFID) and external stakeholders.

Purpose

The overall purpose is to ensure the best possible evaluation product to meet the purpose outlined above.

The purpose of the Management Group is to ensure timely and effective fulfilment of the contract, and effective communication of a credible final evaluation.

The purpose of the Reference Group is to guide the design of the evaluation, quality assures the evaluation outputs, and ensure the evaluation has credibility across the range of stakeholders.

The purpose of the Stakeholder Group is to provide constructive challenge and support to improve the evaluation design and products. Stakeholder group members are representatives from key stakeholder organisations who are going to use the evaluation and will want to learn from it.

Together, the Reference and Stakeholder Groups' input should ensure that the evaluation has credibility across the range of stakeholders.

Scope of Work

Management Group

- Management of the contract, day to day input as needed to the evaluation, and ensure links to the other groups.
- Review and provide inputs to all evaluation deliverables.
- Ensure development and implementation of an effective communications plan and ensure that evaluation products are accessible and understandable to different audiences.
- Publish the management response to the final evaluation report findings and recommendations, including actions will be taken as a result.
- The Management group is the ultimate decision making group.

Reference Group

- Inform, shape, helping to define the format and scope of the evaluation, review and quality assure evaluators' proposed research design including evaluation questions and workplan.
- Quality assures interim and final outputs from evaluators.

Stakeholder Group

- Inform and test the design of the evaluation and evaluation products
- Provide a sounding board to test the findings as they emerge

Membership

Table 11: List of key stakeholders

Management Group	Reference Group	Wider Stakeholder Group
Iain Jones, *Deputy Head & Economist, Health Services Team*	Murray Cochrane, *NHS Trust Development Authority*	Andrew Jones, THET
Nicola Watt, *Global Health Policy Adviser, Health Services Team*	Nick Tomlinson, *Head of International Health, DH and Chair International Academy of Medical Royal Colleges*	Dan Ritman, THET
Mary-Ann Taylor, *Programme Manager, Health Services Team*	Adrian Nembhard, *DFID Evaluation Accredited*	Viki Tayler, THET
	Iain Jones, DFID	Claire Vallings, DFID Governance Open Societies Dept working on partnerships
	Nicola Watt, DFID	Lizzie Smith, DFID Head of Profession Health
	Mary-Ann Taylor, DFID	Julia Watson, DFID Senior Economic Adviser, Human Development
		Neil Squires, PHE/FPH/ Academy of Medical Royal Colleges
		Shams Syed, WHO
		Other invited participants as needed

Ways of Working

The work of the governing groups will be performed by email, meetings and workshops at key points in the evaluation process (as outlined in the *HPS Evaluation Governing Groups Workplan*).

Annex 7: Bibliography

References:

1. Selfless (2016) “Elective Engagement Final Report: Inspiring the Next Generation of Global Health Leaders.”
2. Scanteam (2011). “Review of Norwegian Esther /FK Health Exchange Programme.” Final Report. Jan 2011.
3. Jones K et al (2016). “Exploratory Study to Identify the Benefits of NHS Staff Volunteering Overseas.” LSTM June 2016.
4. The NHS Constitution. “Health Education England (HEE) Toolkit for collection of evidence of knowledge and skills gained through participation in an international health project.” (no date)
5. Stark M (2015). “Draft Paper on Promoting NHS overseas volunteering by a new pension scheme”
6. Saddler L (2016). “Improving Global Health (IGH) report – Evaluating the impact of returned fellows.” March 2016.
7. SEED Global Health (2015). “Sharing Knowledge, Strengthening Health Systems, Saving Lives.” Annual Report 2015.
8. Baxi R (2015). “Health systems strengthening in low and middle income countries: UK partnerships at the systems level.” iDSI, Oct 2015.
9. DFID Governance, Open Societies and Anti-Corruption Department (GOSAC) (2016). “(UK Partnerships: Lessons Learned.” (Draft) April 2016.
10. WHO (2015). “Partnerships for Safer Health Service Delivery: Evaluation of WHO African Partnerships for Patient Safety 2009-2014.”
11. HPS VFM analysis 2015/2016. London, THET.
12. Augmented HPS grants guide - Full dataset of HPS 1 & HPS 1.5 grants
13. Annex H_HPS Grants Overview FINAL.docx – Overview of calls for proposals
14. HPS Duty of Care Toolkit
15. HPS Grant Management Manual v2.0 - Toolkit that documents THET’s practice in grant management.
16. HPS Grant Status Traffic Light - Performance/RAG rating for each project
17. HPS inception documents - HPS inception report, budget, MEL framework, workplan.
18. HPS Fraud, Bribery and Corruption Toolkit
19. HPS Logical Framework
20. HPS 1 & 1.5 Grant Giving Summary - Financial information at the portfolio level for HPS 1 and HPS 1.5: funds committed, awarded, disbursed.
21. HPS 6 month and annual reports to DFID, including feedback and follow up.
22. HPS2: Some proposals and considerations for a successor to the Health Partnership Scheme.
23. Returned volunteer surveys (survey monkey)
24. THET’s Approach to Due Diligence in Grant Selection and Management
25. 151130 HPS Quantitative Data Sheet V4.0 - Captures all quantitative data which projects report on every 6 months

Documentation at the individual project level:

- Grant application
- Contract
- Organisational assessment
- Project MEL plan

- Project reports
- Meeting notes
- Grant summaries

Annex 8: List of participants

The list of participants is attached separately as it is not to be shared or published.

Annex 9: Survey Reports

9.1. Volunteer Survey Report

9.2. Overseas Partner Survey Report

9.3. UK Partner Survey Report

9.1 Volunteer Survey – Report

After data cleaning there were a total of 113 valid responses to the volunteer survey. Note that some questions were not completed by all respondents, thus 'n' varies for a number of questions. Also note that for a number of the survey questions, respondents were able to tick more than one response, meaning that the total % often adds up to more than 100%. Lastly, please note that this report does not include analysis of the majority of the qualitative responses as these have been analysed separately using NVIVO.

Basic volunteer demographics:

The majority of volunteer respondents (77%) were female:

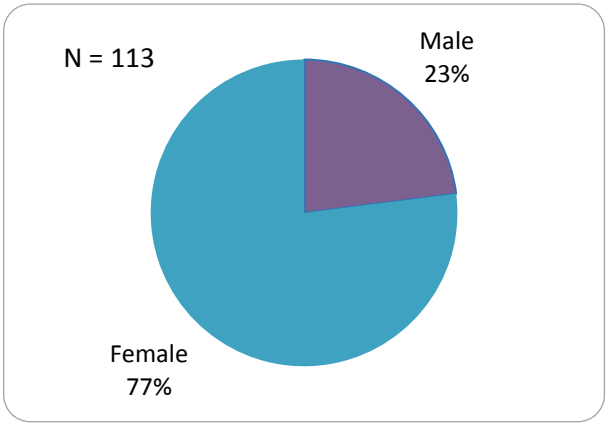


Figure 22: Gender of volunteer respondents

Just under a third of respondents were aged 41-50 years old at the time of volunteering. 20% were aged 21-30 years and nearly 10% were over 61 years. None of the volunteers were under the age of 20 at the time of volunteering.

Of the 26 male respondents, cross-tabulations demonstrate that 23% were aged under 40 and 77% were aged over 41 years. The age range of female volunteers was more equally distributed, with 47% aged under 40 years.

Age at time of volunteering:

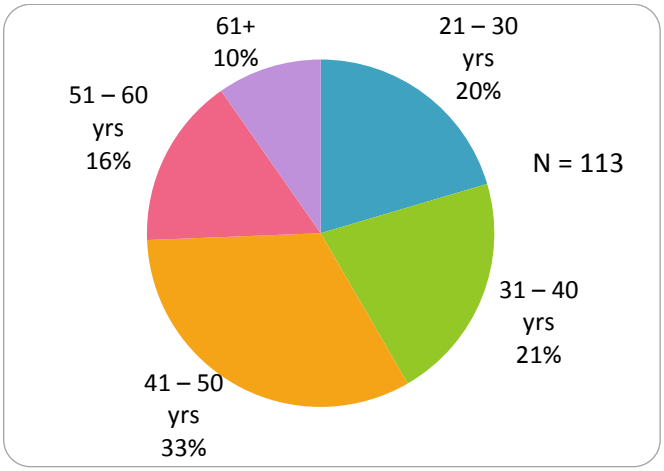
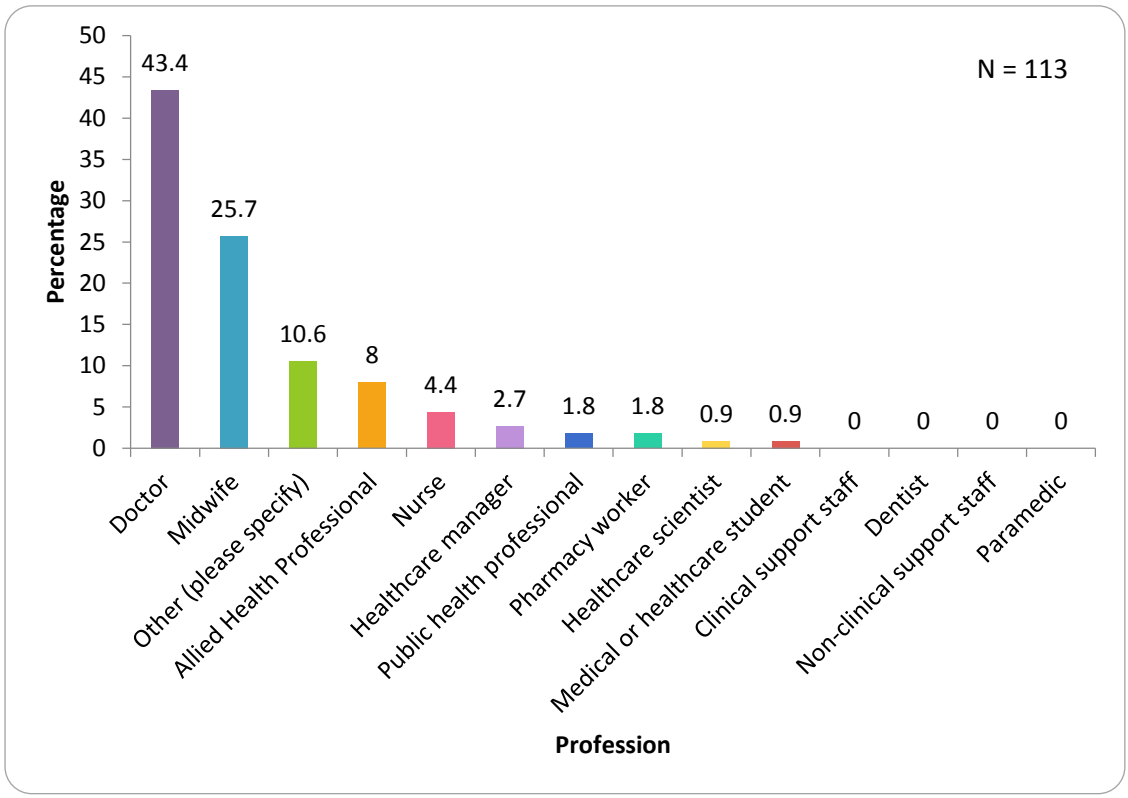


Figure 23: Age of volunteers

The largest proportion of respondents were Doctors (43%) followed by midwives (26%). Professions listed in the 'other' category included health visitor, trainee health psychologist, student, teacher/lecturer and retired professional.

Profession:

Figure 24: Profession of survey respondents



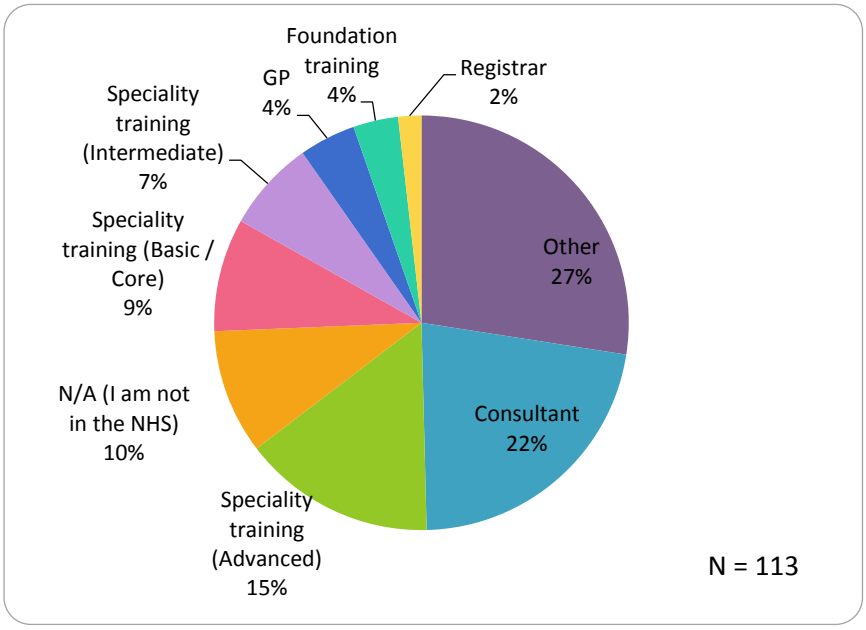
Nearly two thirds respondents (63%) stated their ethnic group was white; 15% stated this was Black/African/Caribbean and 13% Asian or Asian British. This question was asked for assessing equal opportunities.

11% (n=8) of respondents were diaspora volunteers from the host country. Countries were India, Zimbabwe, Uganda, Ghana and Myanmar.

When asked about their career stage, 22% of respondents stated that they were consultants and 35% of respondents were undertaking training (foundation-basic-intermediate-advanced). 27% of respondents stated their profession was not included in the categories listed - and in the responses provided the most commonly cited profession was midwife, followed by nurse. Just under 10% of respondents stated that they were not in the NHS.

Career stage:

Figure 25: Career stage of respondents



Volunteer sending agency:

Not surprisingly, the NHS was the most commonly cited employer. A range of trusts, foundations and specific health facilities across the UK were provided.

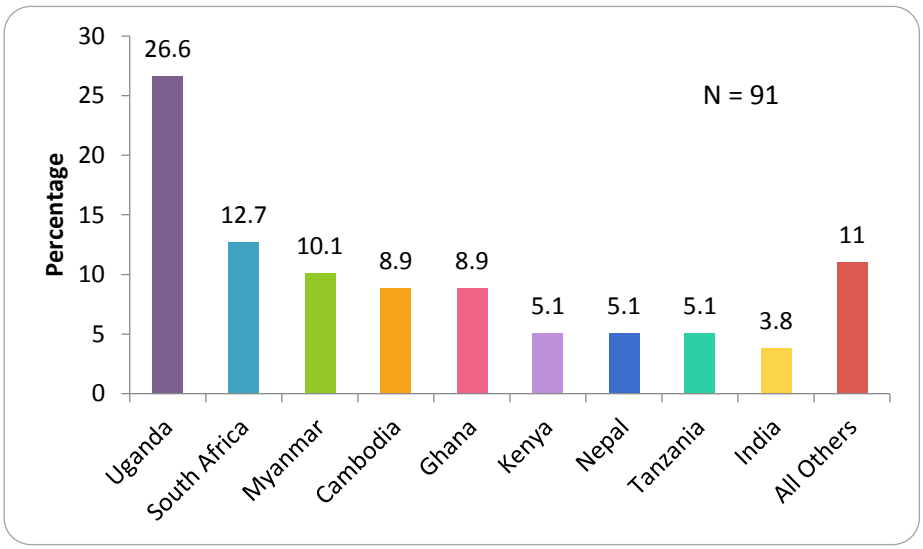
66 respondents stated that their volunteering opportunity had been organised by a UK partner organisation that was not their direct employer. The most commonly cited organisation that organised the placement was the Royal College of Midwives (n=10).

Volunteering assignment:

A total of 91 respondents had volunteered overseas. Of these, 45% had undertaken one overseas volunteering placement, 21% had done two, and 26% had done between three and five placements. Eight volunteers had each done between seven and 20 volunteering placements overseas.

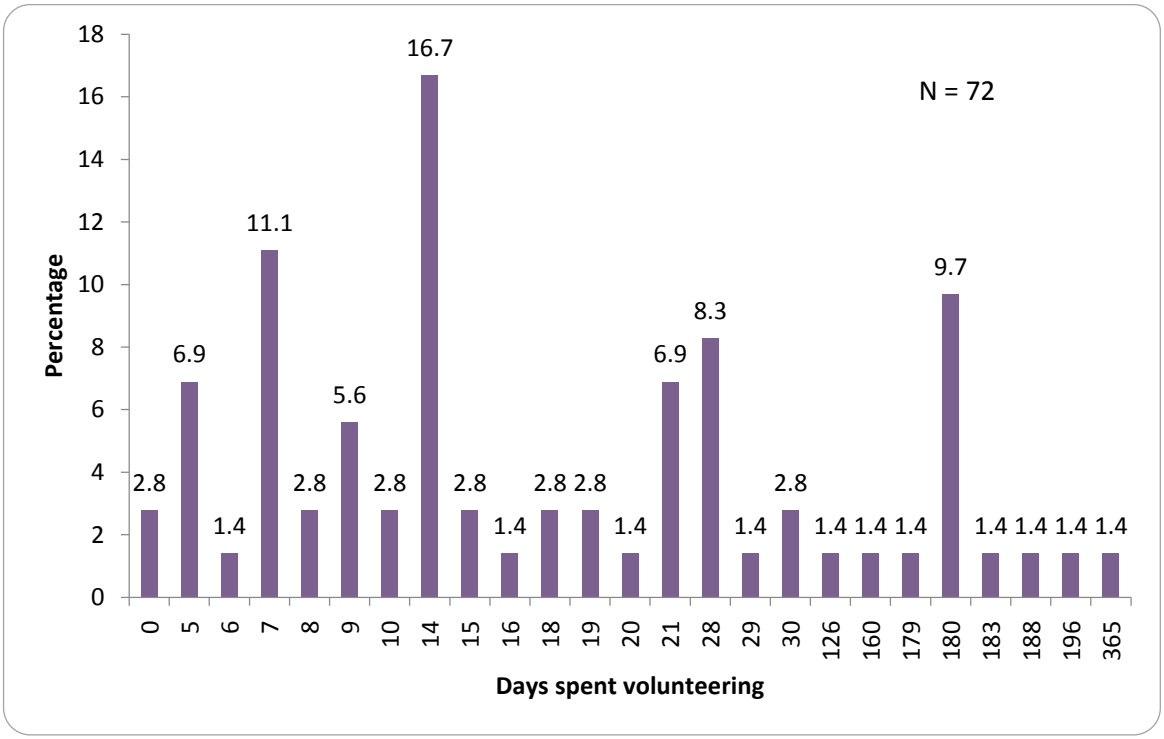
More than a quarter (27%) of respondents had visited Uganda during their most recent HPS volunteering placement. The other most commonly cited countries were South Africa (13%), Myanmar (10%) and Cambodia (9%).

Figure 26: Country of last HPS - funded assignment



Of the 72 volunteers who responded to the question around days spent overseas during their last HPS volunteering assignment, the largest proportion (17%) spent 14 days volunteering overseas, 11% spent 7 days and 10% spent 180 days overseas. In the sample of respondents, a total of 3,486 days were spent volunteering overseas.

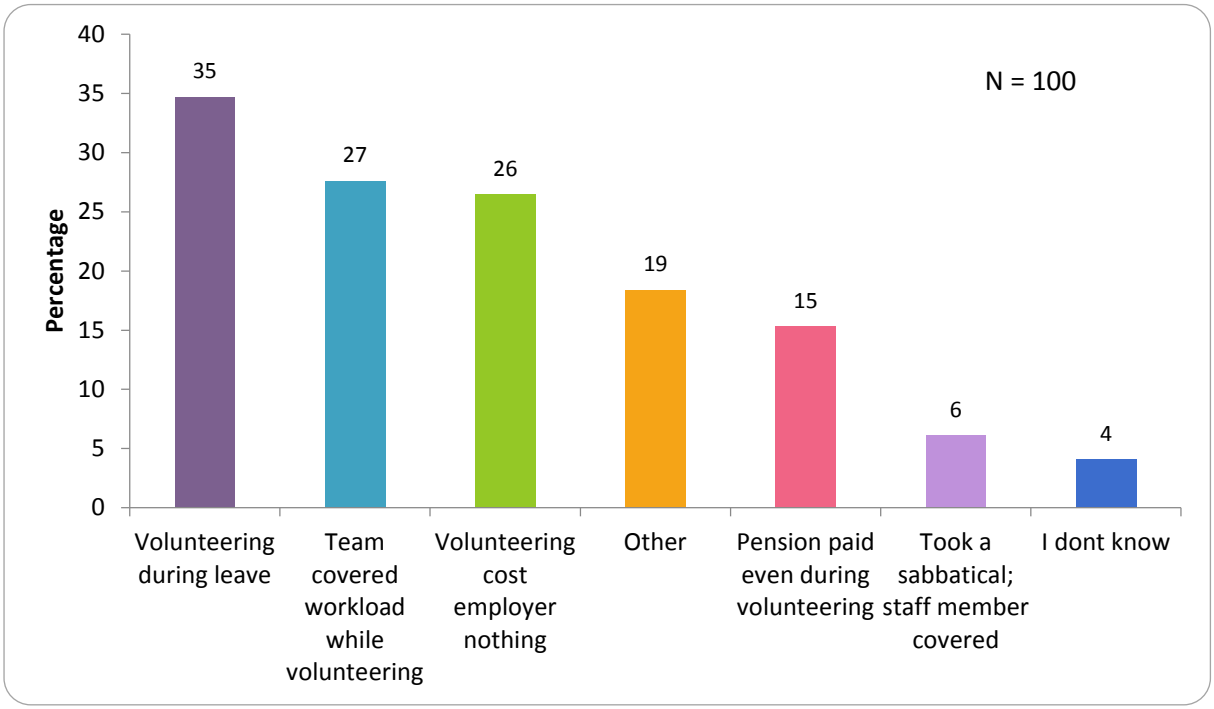
Figure 27: Days spent overseas during last HPS-funded volunteering assignment (weekends included)



Statistics	
Total Responses	72.0
Min	0.0
Max	365.0
Sum	3,486.0
Average	48.4
StdDev	73.4

The graph below demonstrates whether the volunteer's absence was covered by their UK employer, and if so how. 35% of respondents undertook their volunteering placement during their own annual leave and 26% of respondents stated that their volunteering overseas was at no cost to their employer. 27% of respondents had their work covered for them by a team member whilst they were away. Options included in the 'other' response were taking a sabbatical/career break, being a student, or leaving their job.

Figure 28: How team or UK employer covered for volunteer's absence



Skills transfer:

A total of 1,688 men and 2,307 women were reported to have benefited from the training or mentoring provided by volunteers during their most recent volunteering assignment.

When asked what the main changes that were observed among overseas colleagues as a result of training or coaching, a wide range of responses were provided (and are analysed elsewhere). Examples of common responses included improved technical/hard skills in their field of work, improved leadership and facilitation skills, increased confidence in management decisions and personal abilities, and better multi-disciplinary working.

When asked to rate the improvement in skills and capacity of health workers and other staff with whom the volunteers engaged (on a scale of 1-10 where 1 was no improvement and 10 was significant improvement), a score of '7' was the median value given (and cited by 29% of respondents). The mean score was 6.4.

For the health workers and other personnel that you engaged with - how would you rate the improvement in their skills and capacity?

Figure 29: Respondents rating on the improvement of their skills and capacity

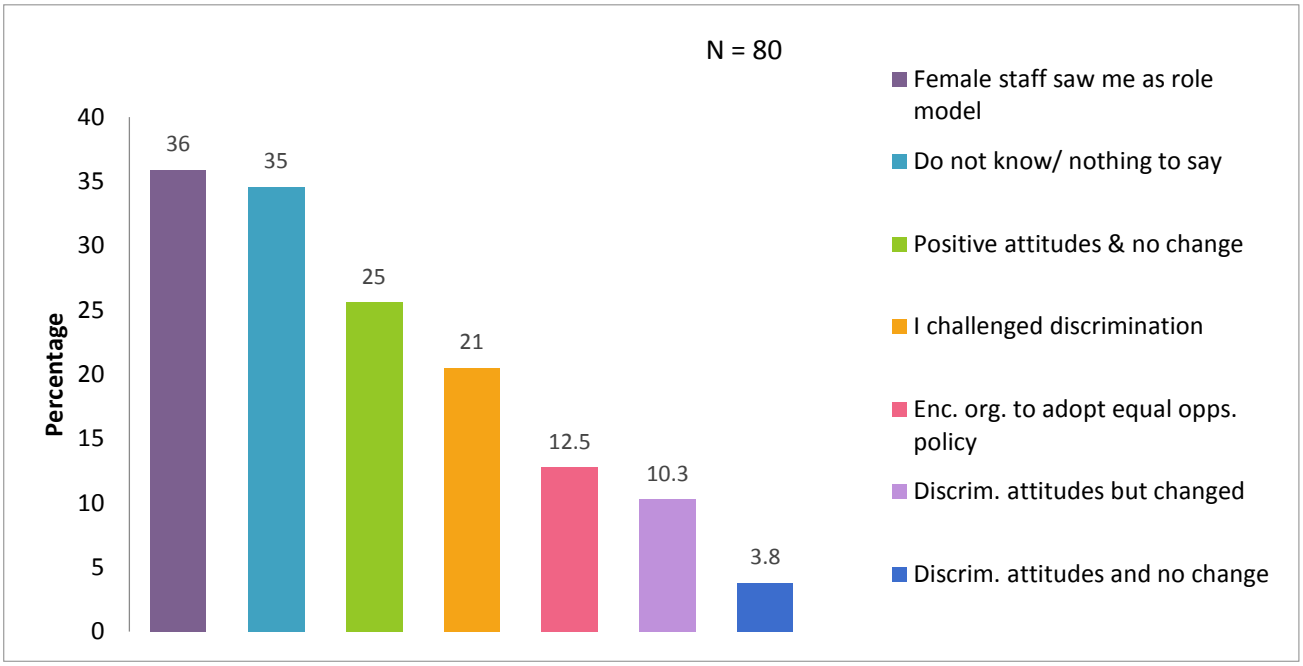
Volunteers cited a wide range of evidence to demonstrate these changes in workforce skills and capacity, including volunteers' own observations (88%), pre and post training tests (43%) and feedback from supervisors (also 43%). 18% of volunteers had conducted interviews with service users and 16% had conducted surveys with service users to demonstrate changes in skills and capacity. Less than 4% used a formal appraisal system.

Table 12: Evidence for improvement in skills and capacity

Value	Percent	Count
My own observation	87.5%	70
Pre and post training test	42.5%	34
Feedback from supervisors and managers	42.5%	34
Interviews with health workers	38.8%	31
Other - Write In	18.8%	15
Interviews with service users	17.5%	14
Surveys with service users	16.3%	13
Formal appraisal systems	3.8%	3

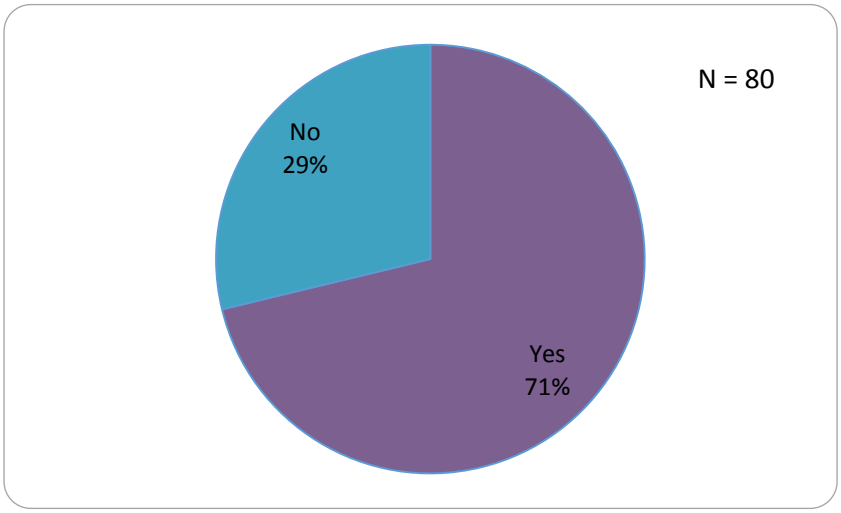
Volunteers were asked whether there were any changes in the attitudes or behaviours of health workers around gender equality, as a result of their engagement. Results were quite mixed. 36% of respondents (female) saw themselves as role models for women health workers, 21% stated that they had challenged discrimination during their placement, and 10% stated that they had encouraged institutional changes through adoption of equal opportunities policies. 10% also felt that they had changed attitudes amongst health workers towards gender equality for the better. However, 25% of respondents also stated that existing attitudes towards gender equality were positive and had not changed as a result of their visit and 35% (n=28) stated that they either didn't know or had nothing to add about gender equality. Of this latter group, cross tabulations demonstrated that 68% (n=19) were women, and the same number were aged over 41 years.

Figure 30: Changes in attitudes/ behaviour of health workers around gender equality



Nearly three quarters of survey respondents (71%) had continued to provide remote support after they had returned from their volunteering assignment overseas. For most, this took the form of email support, or whatsapp/skype or other forms of social media. The remote support included ongoing mentoring to health workers, as well as support and advice to new volunteers or project management staff overseas.

Figure 31: Continuation of remote support provided following overseas assignment



Personal and professional development:

The large majority of respondents (93%) felt they had benefited from their volunteering experience with HPS (n=76). Cross tabulations demonstrated that of these, 32% were still in training. Only 5 volunteers felt that they did not benefit in any way from their overseas experience. Cross tabulations demonstrated that 4 of these 5 respondents were Consultants (i.e. senior level). Five of the eight diaspora volunteers felt that they had benefited from their volunteering experience.

Ways in which volunteers have benefited include strengthened technical/hard/clinical skills, increased soft skills (confidence, motivation, leadership etc.), and international exposure and improved cultural awareness. These results are analysed in more depth elsewhere, but some examples of the ways in which volunteers feel they have benefited are included below:

“Confidence in something I have not done before. Dealing with different cultures.”“

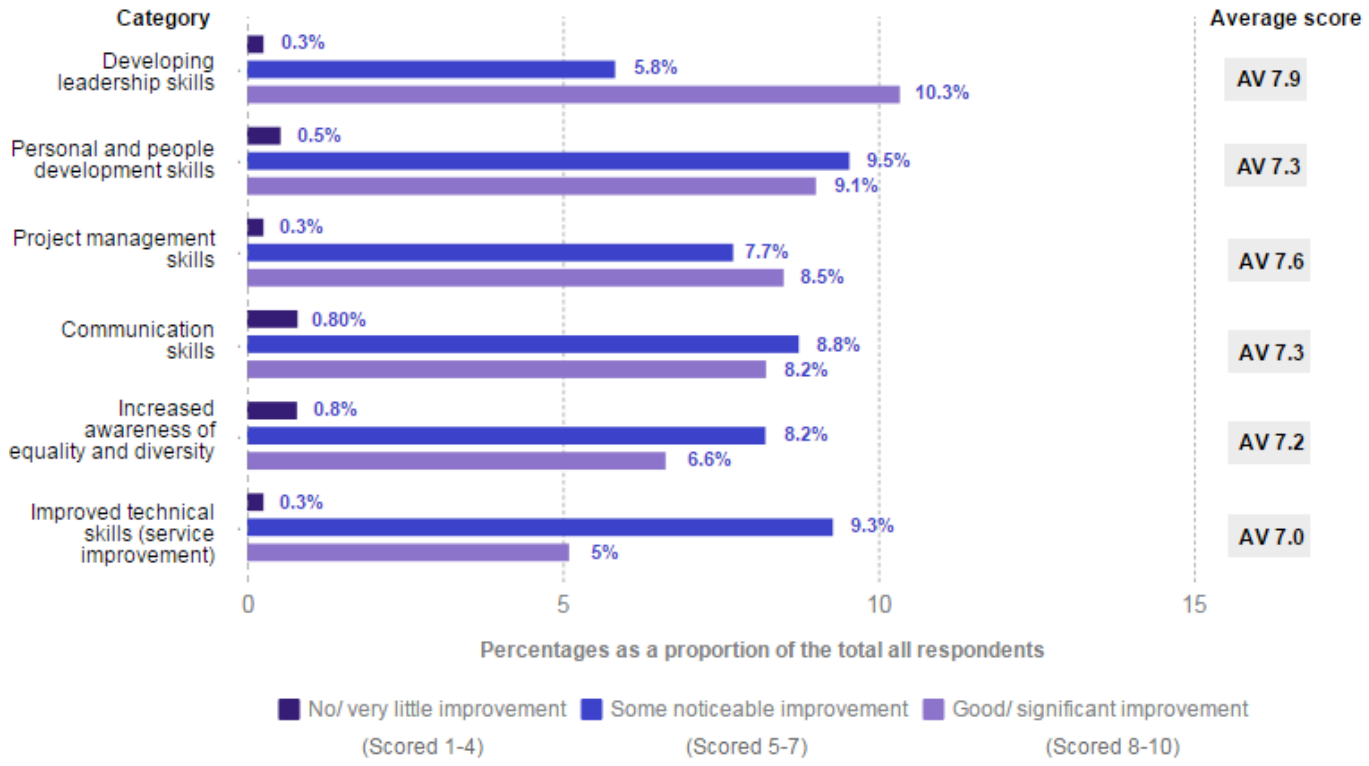
“I have an increased understanding of low resource countries and their problems and the difficulties faced. My political and personal views have become more focussed. I am more aware of human and particularly women's rights. I have an increased interest to learn more and become active in my beliefs. I am more self aware of how I speak to and treat others. I have gained confidence to speak out and discuss political and human aspects of healthcare in this country and abroad. It has ultimately given me the confidence to take time out from my full time job to go to university to study peace and development.”

“Invaluable experience to develop leadership skills, learn about my own competencies and self-development to realise areas of difficulty and why they occurred. I learnt a lot about the NHS and why our systems may have developed as they have and also I learned how similar human behaviour is across cultures/borders, which I believe is a strong realisation to help me in any future roles of leadership and how to influence for positive change.”

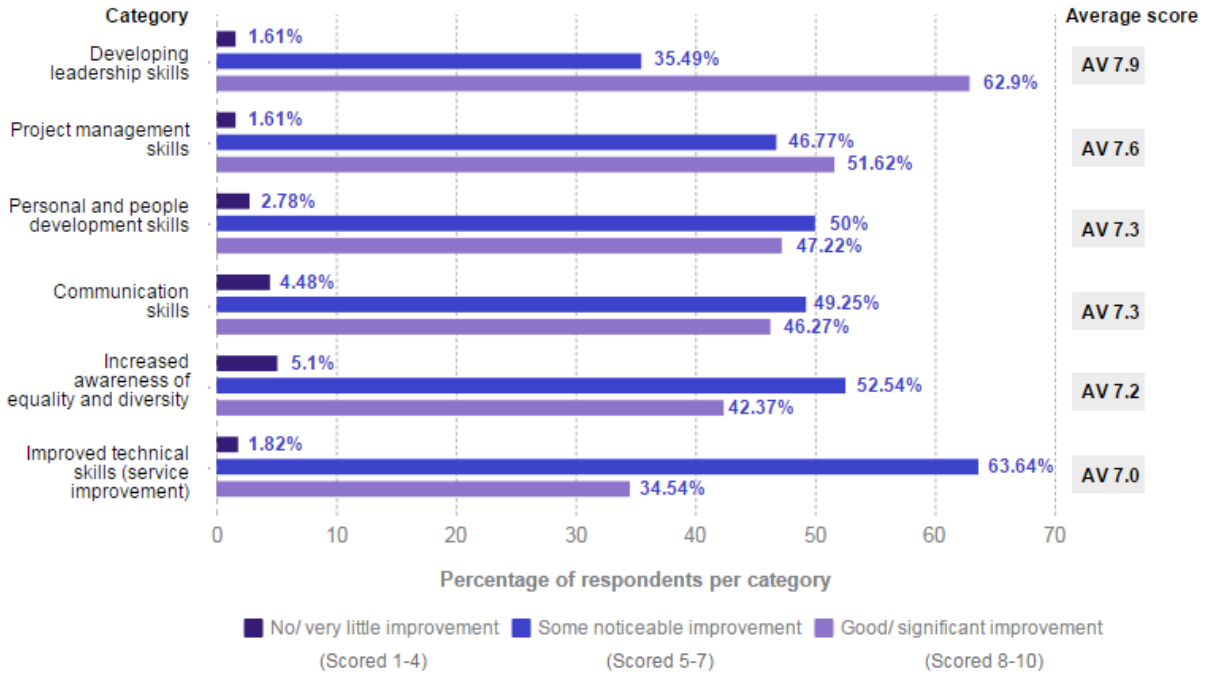
“Skills - teaching training mentoring clinical work and running projects, managing people and funding. Experience - different ways of working and dealing with people, appreciation of different culture. Knowledge - vast increase in clinical skills as honed these whilst less technology available.”

The graph below demonstrates the specific skill areas which volunteers felt they had developed whilst volunteering overseas. Leadership skills and personal and people development skills were rated most highly – in terms of the proportion of people who felt they had seen a significant improvement in these skill areas.

Figure 32: Skills improvement as a result of volunteering overseas



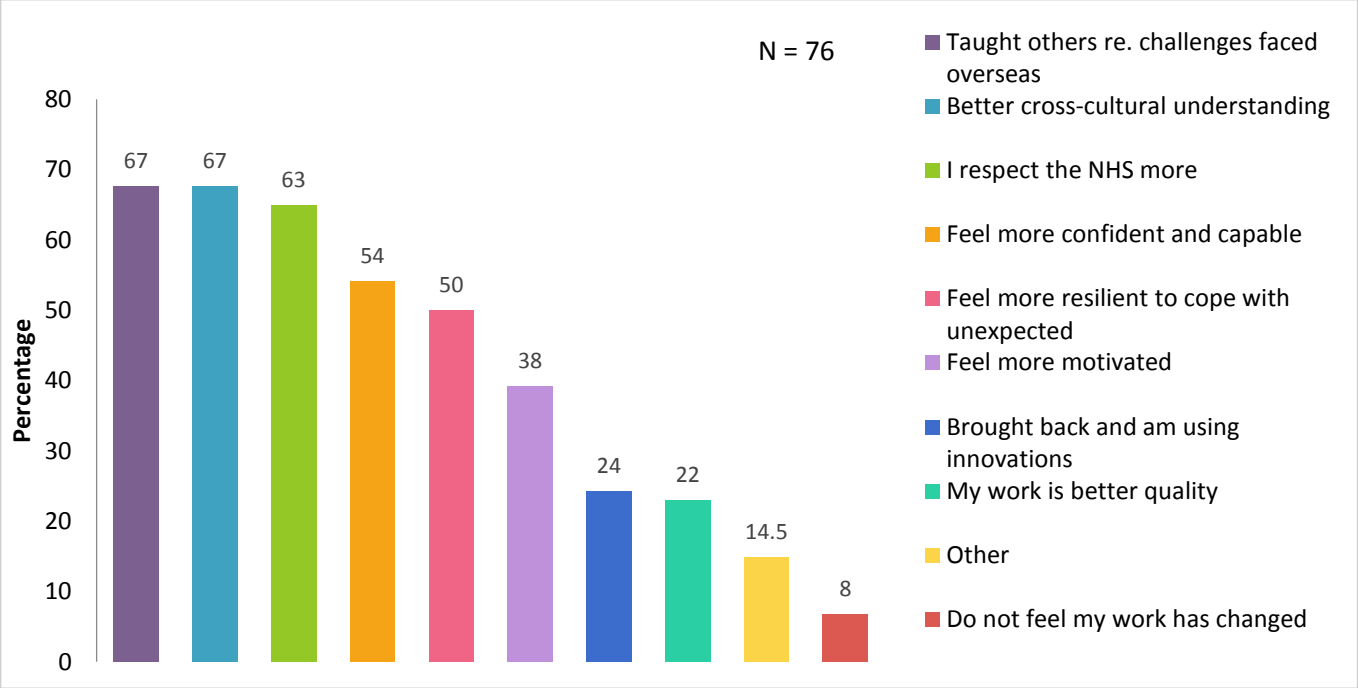
The graph below presents the same data, but with the percentages presented as a proportion per category or skill area (as opposed to proportion of all respondents).



On their return from their overseas volunteering experience, respondents cited a wide range of benefits to their work in the UK. More than two-thirds (67%) of respondents stated that they had taught others in their organisation about the challenges that health workers face overseas, and that they had better cross-cultural understanding. 63% stated that they respected the NHS more and 54% felt more confident and capable in their jobs as a result. 24% felt that they had brought back innovations which they were now using in their work in the UK. Only 8% (n=6) felt that their work in the UK had not changed as a result of their volunteering experience (4 of the 6 were aged over 41 years). Several of the responses in the 'other' category were volunteers stating they had not yet returned to the UK.

Cross-tabulations demonstrated that of the 24% of respondents who felt they had brought back innovations to the UK, 28% (n=5) were in speciality training. Of the 17 respondents who said their work was better quality than before, 65% of these were aged under 40 years. Of the 38 respondents who felt more resilient as a result of their volunteering experience, 79% were aged under 40 years. Of the 18 consultants who answered this survey question, 50% felt they respected the NHS more and 61% (n=11) had taught others about the challenges health workers face overseas.

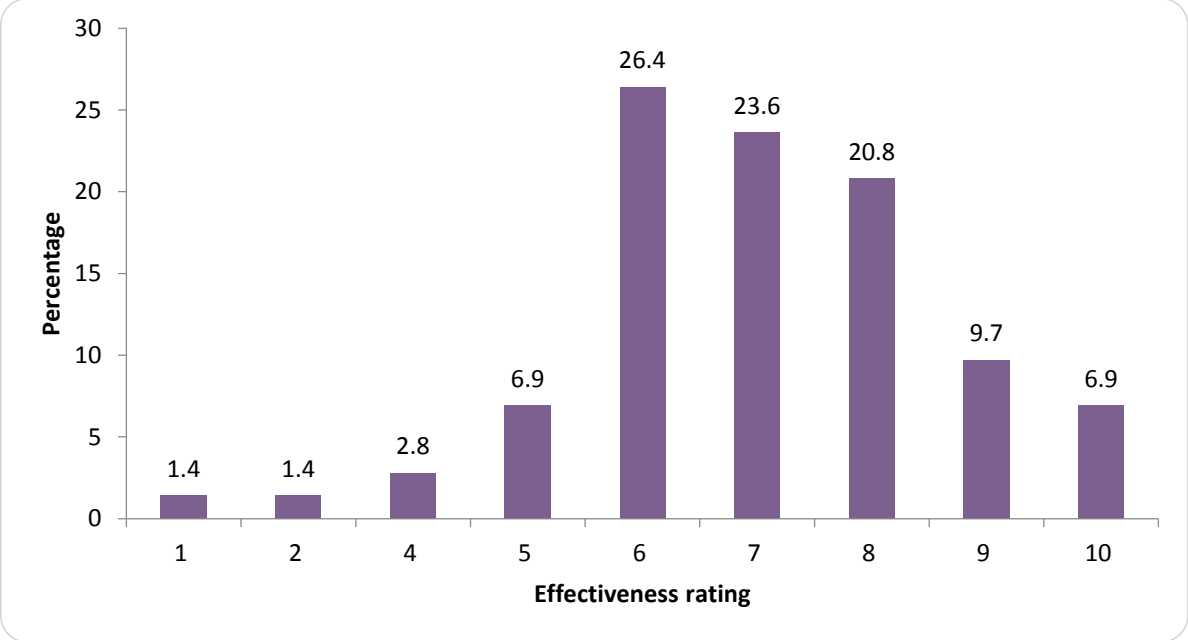
Figure 33: Benefits to work in the UK



Effectiveness of HPS:

When asked to rate the effectiveness of the HPS programme in strengthening the institutional capacity of partner organisations overseas (on a scale of 1-10 where 1 was not effective and 10 was very effective), a score of '7' was the median value, and a score of 6 was cited the most often - by 26% of respondents. 7% (5 respondents) felt that the HPS programme is very effective in strengthening overseas partners' institutional capacity (n=72).

Figure 34: Effectiveness of HPS programme in strengthening the institutional capacity of partner organisations overseas



Some of the qualitative examples of the ways in which HPS has strengthened institutional partner capacity included:

"*It provides the partner with regular volunteers whom are able to provide continuity in supporting ongoing projects. It brings health professionals with a wide background and different skills to feed into a health team,"*

"Institutions are already implementing some of the changes we discussed and reporting benefits even in the short term" and

"Very early to say in terms of leadership development as we are early in the project, but carried through as projected there is real potential for building capacity through Quality Improvement and leadership development at various levels in the organisation."

Suggestions to improve the effectiveness of the HPS programme included:

"*Longer secondments in country. True twinning with Cambodian midwives spending time in the UK"*

"Better continuation of tasks and projects between each cohort of volunteers", "Support to influence at national level" and "*To have a regional or country specific network of all the HPS funded programmes so that we could share expertise and findings."*

One respondent suggested: "*More variety of long term and short term placements to build lasting relationships and to encourage participants who have commitments at home to take part in volunteer projects. Publicity in NHS Trusts to promote the value of volunteering and encourage management to support volunteers, particularly on return. Ongoing research about the effectiveness and sustainability of projects, what works and what doesn't, short term and long term effects."*

The vast majority (97%) of respondents would recommend volunteering through HPS to a colleague.

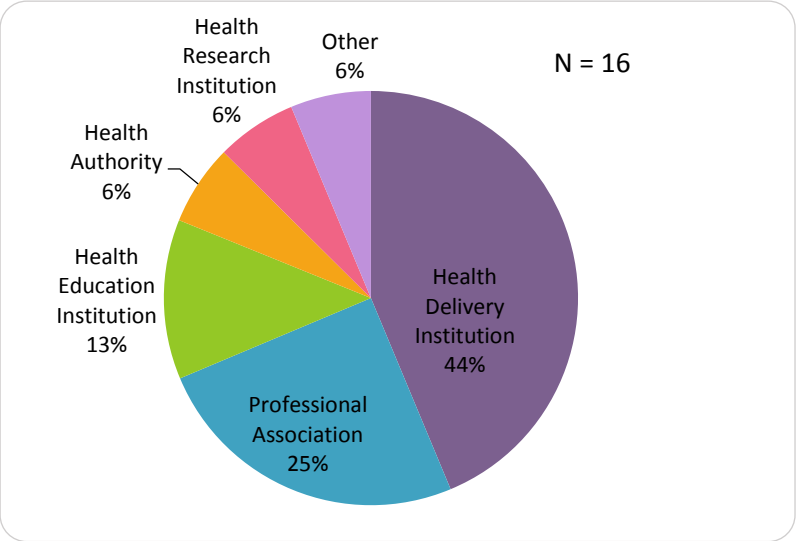
9.2 Overseas partner survey – Report

After data cleaning there were a total of 16 valid responses to the host partner survey. The small sample size may be due to the fact that the evaluation team was reliant upon the UK partner organisation sending the survey onto their overseas partner. There were also a large number of respondents (33) who inputted basic data on the first page of the survey but then chose not to continue with the remainder of the survey. Reasons for this are unknown but could be due to poor internet connectivity or lack of time/interest etc. These responses are not included in the final sample. Due to the small sample size, results should be interpreted with caution. Also note that for a number of the survey questions, respondents were able to tick more than one response, meaning that the total % often adds up to more than 100%. Lastly, please note that this report does not include analysis of all the qualitative responses as these have been analysed separately using NVIVO – instead highlights are provided.

Basic respondent demographics – overseas partner profile:

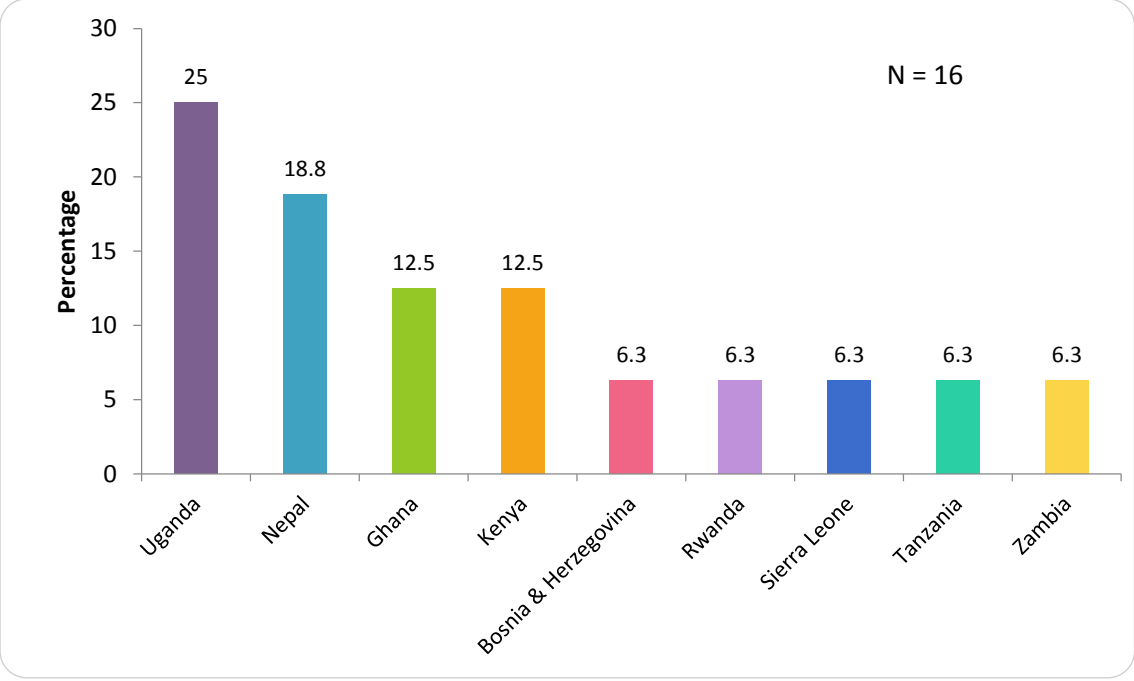
Individuals from a variety of overseas organisations responded to the survey - including hospitals, midwifery associations, nursing associations and university departments. The majority of respondents were from health delivery institutions (44%; n=7), followed by professional associations (25%; n=4) and health education institutions (13%; n=2).

Figure 35: Overseas partner organisation type:



Respondents were from a range of countries across Africa, Asia and Europe, as demonstrated by the graph below. There were the greatest number of respondents from Uganda (n=4) and Nepal (n=3).

Figure 36: Partner organisation location



Organisations were partnering with a range of UK institutions, including the Royal College of Midwives, Royal College of Paediatrics and Child Health, Royal College of Nursing and a number of specific hospitals and universities. Four partnerships had been in existence for 0 - 2 years, six partnerships for 3 - 5 years and six partnerships for 6 - 9 years. Survey respondents were associated with HPS projects working in a range of fields including midwifery, nurse leadership, patient safety and mental health.

Project profile

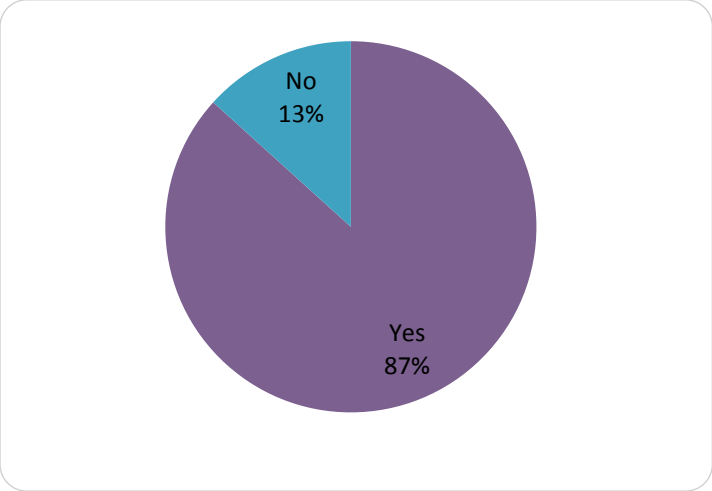
Four projects were completed at the time of respondents filling out the survey, 11 projects were finishing by or before April 2017 and 1 project had not yet started (and didn't state end date). (NB. This respondent did not answer any further questions in the survey).

Project budgets ranged in size from just under £5000 to £680,000. The average project budget size in the sample of respondents was £182,284.

Partner Inputs

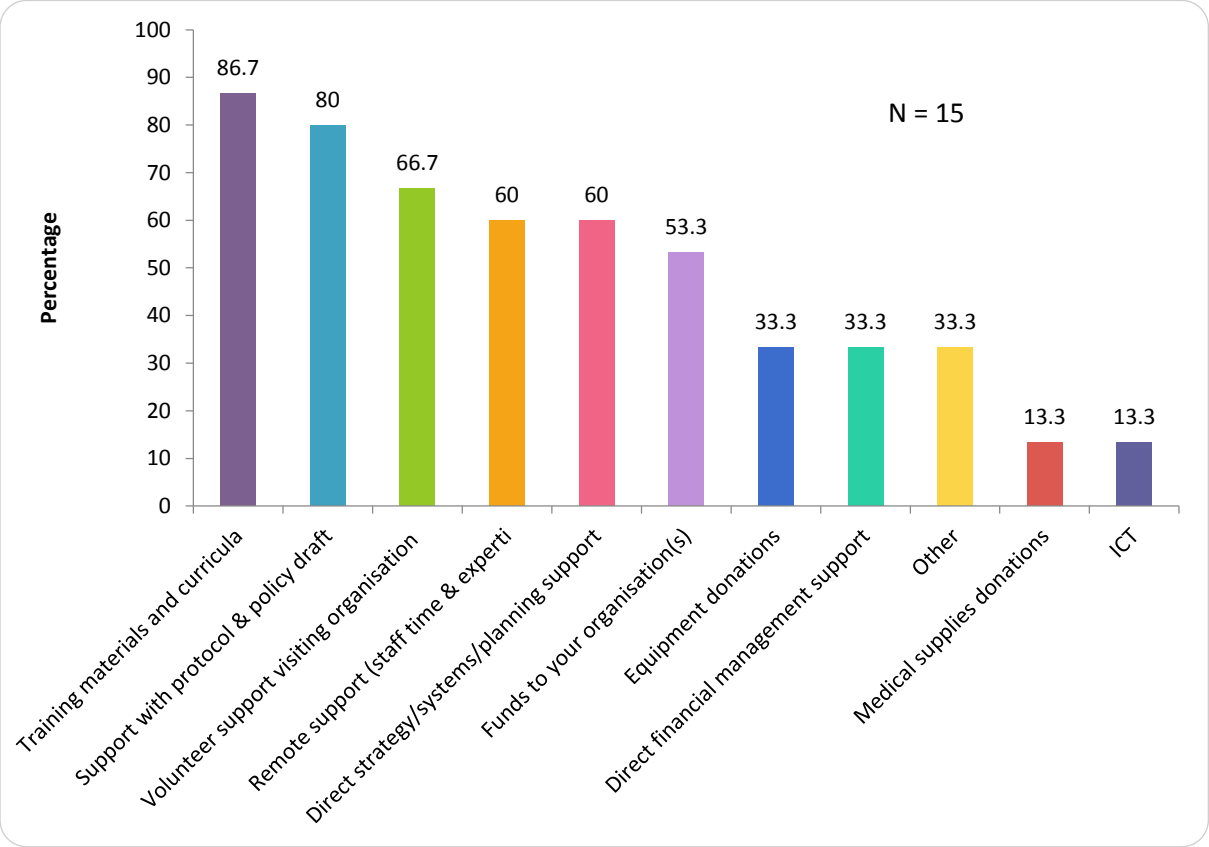
The majority (87%; n=13) respondents stated that their organisation had received volunteers in-country from the UK partner organisation as part of their HPS project.

Figure 37: Hosting of UK volunteers



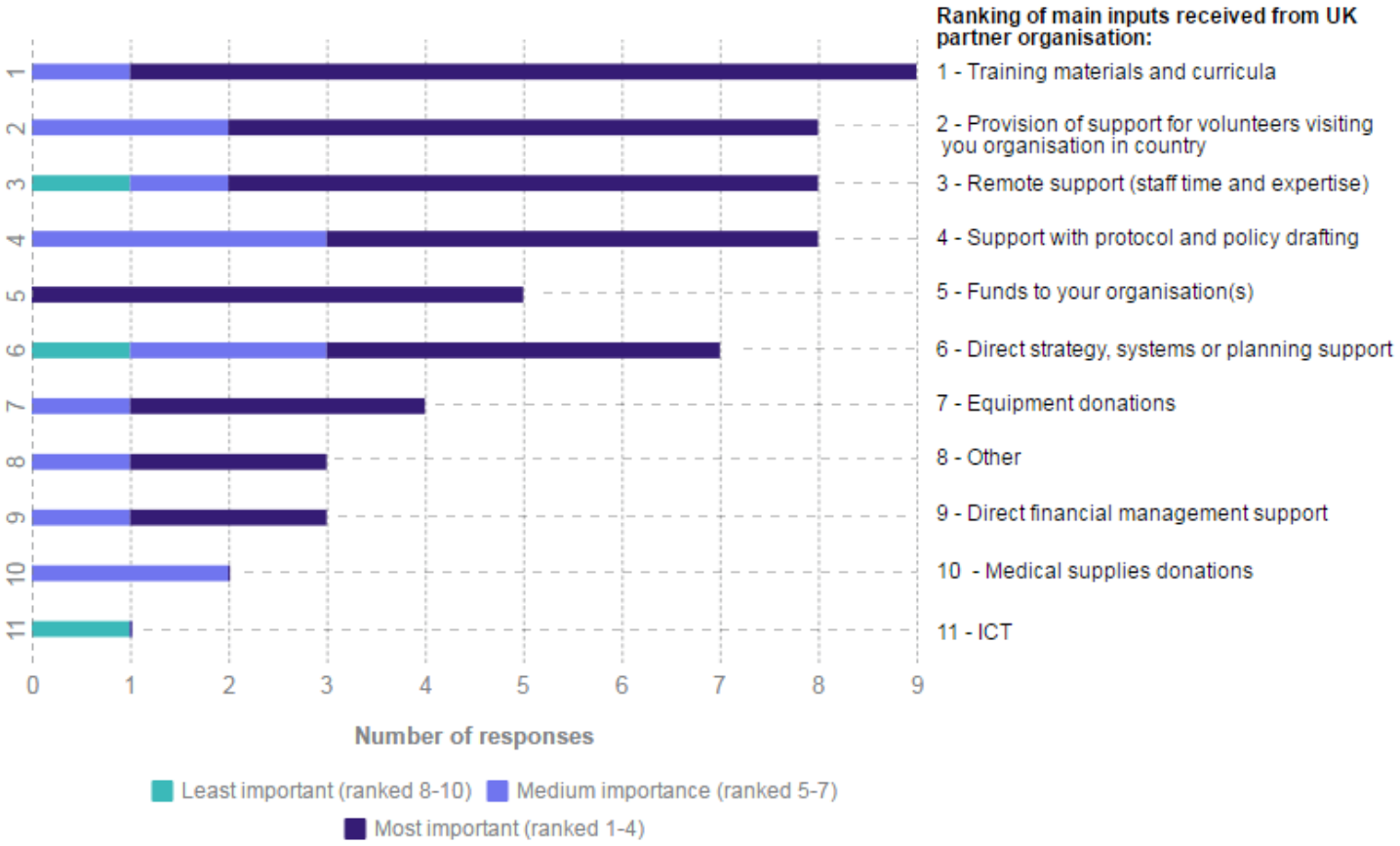
As demonstrated by the graph below, when asked what the main inputs were from the UK partner, the most commonly cited response was training materials and curriculum (87%; n=13); followed by support with protocol and policy drafting (80%; n=12); and in-country volunteer support (67%; n=10). This is broadly in line with responses from the UK partner survey.

Figure 38: Main inputs from UK partner organisation



The graph below demonstrates how respondents ranked the main inputs received through the UK partner organisation (based on their responses to the previous question – see above graph) (note that not all respondents to the earlier question answered this question).

Figure 39: Respondents ranking of main inputs received through UK partner organisation



When asked to expand on their ranking of partnership inputs, a number of comments were made including around volunteer inputs and support with training:

"The role played by the volunteers in behavioural change and ensuring the success of the project was a crucial intervention to the project as they had lots of expertise in their work,"

"The stimulus and enthusiasm of having partners from UK visiting increases momentum and focus and really helps move things forward. In particular the support offered to our Patient Safety Nurse has been really valuable. The input into training for our hospital staff and healthcare workers and leaders from our surrounding communities has also been strategic," and

"Support supervision by sending in volunteers was the most important help we got. The training materials were adapted and developed here for local use."

There was also an interesting comment with regards to the value of international exposure and keeping up to date with curricula:

"*Our partners in the UK, apart from direct support from their expertise, they also have been timely updating us on various microbiological issues obtained from scientific conferences in the UK and giving us connections to leaning materials such as http://www.who.int/mediacentre/events/2015/world-antibiotic-awareness-week/en/ We also collected several training materials from our visit to North Cumbria in March 2016. Funds have been directly received by our partners who send the money to our site based on the need and budget requirement at particular time. The scope of our project was discussed agreed together with our partners."*

When asked to rate the extent to which the project inputs received through the partnership contribute to the strategic priorities of their organisation, (where 1 was no contribution and 10 was contributed to a large extent),

respondents rated this quite highly - with a rating of '8' as the median value. Six respondents (43%) felt that the partnership inputs strongly contributed to their organisation's strategic priorities (a rating of 9 or 10).

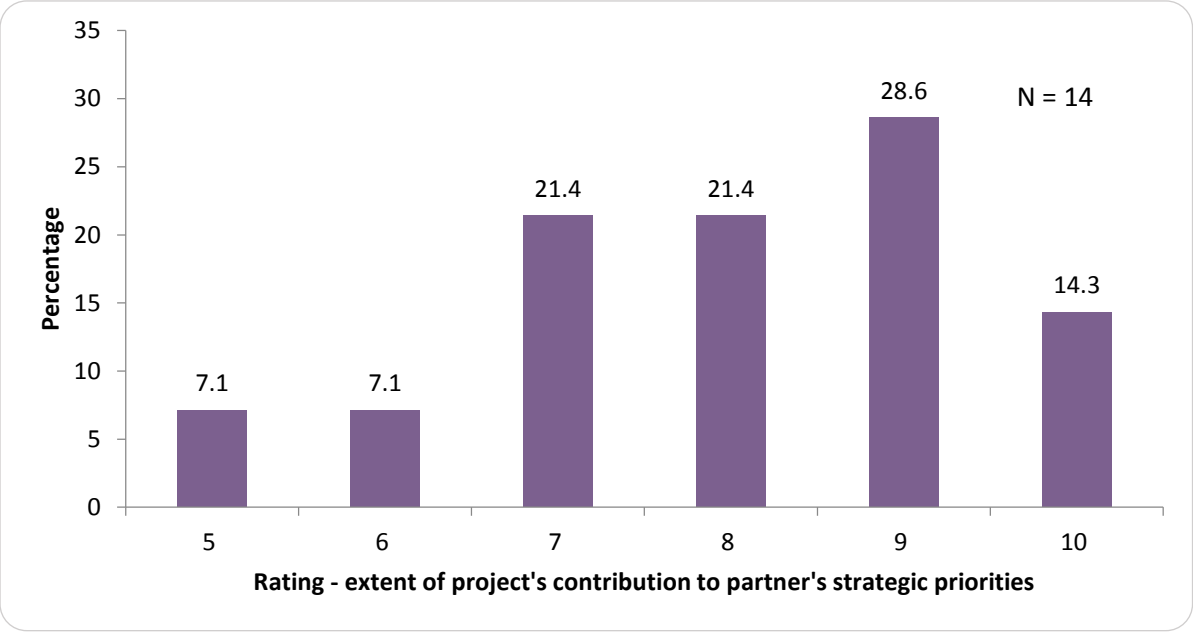
When asked to expand on why this was the case, responses included:

"Maternal and child health and safety are a major priority to UPMA and the project has directly contributed to this through mentorship,"

"Our long-standing partnership with Chester and World Health Organization via the African Partnerships for Patient Safety has been a key input to our Strategic Planning putting patient safety and quality to the forefront of our agendas," and

"Partnership input has greatly contributed to achieving our objectives, which are directed at raising awareness about Epilepsy as a medical condition, setting up of a hub, training of health care personnel for all 14 districts in Sierra Leone."

Figure 40: Extent that project inputs contribute to strategic priorities of overseas partner organisations



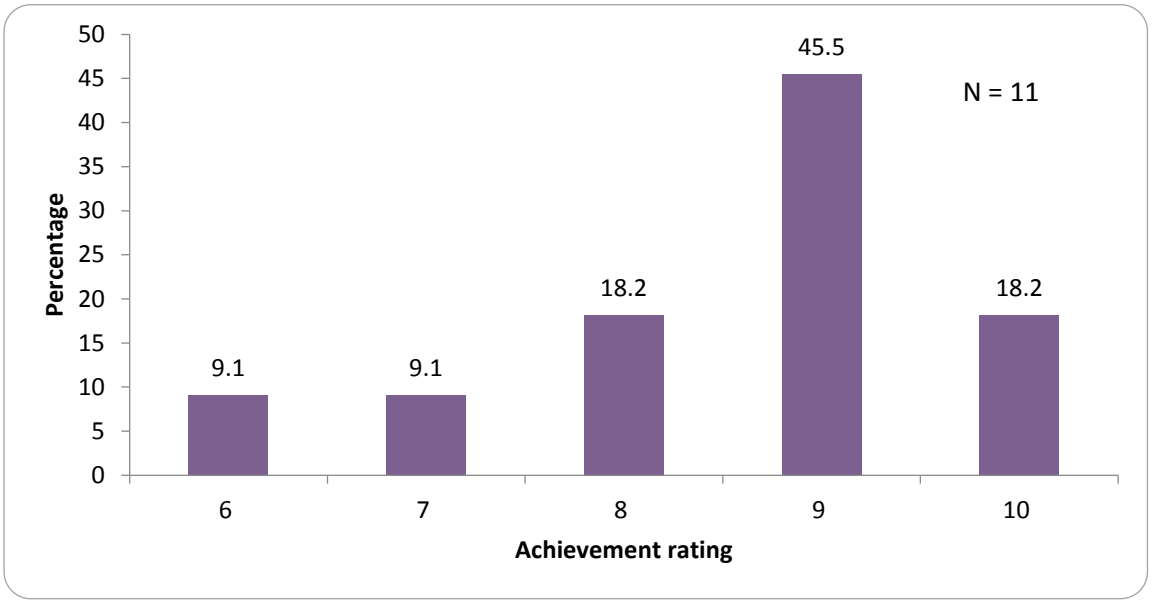
Volunteer inputs:

Open text answers to questions regarding the added value of the support received by the overseas partner through UK volunteers are analysed in more detail elsewhere. Nevertheless, ways in which respondents felt volunteers added value were wide ranging and included:

- Bringing skills and expertise: "*Added expertise and skills for mentoring and support",*
- Systematic inputs in terms of developing standards and accreditation: *"Standards and module development enhanced for nursing and midwifery mentorship,"*
- Improvements in quality of care: "*Significant improvement in patient safety has been achieved" and "Better management of childhood illnesses,"*
- Bringing new ideas and drive: "*Provision of different perspective of looking at things*," and *"Their input has increased motivation and focus,"* and
- Networking and profile raising: "*Linkage with other partners for collaboration and support" and "Visibility of the volunteers activities with key stakeholders, regulators and policy makers."*

When asked to score the achievements of the volunteers in relation to the project objectives (where 1 was volunteers made no significant achievements to the project objectives and 10 was volunteers made significant achievements in relation to project objectives), again respondents rated them very highly. A rating of '9' was the median value and cited by the most number or respondents (5).

Figure 41: Achievements of volunteers in relation to the project objectives

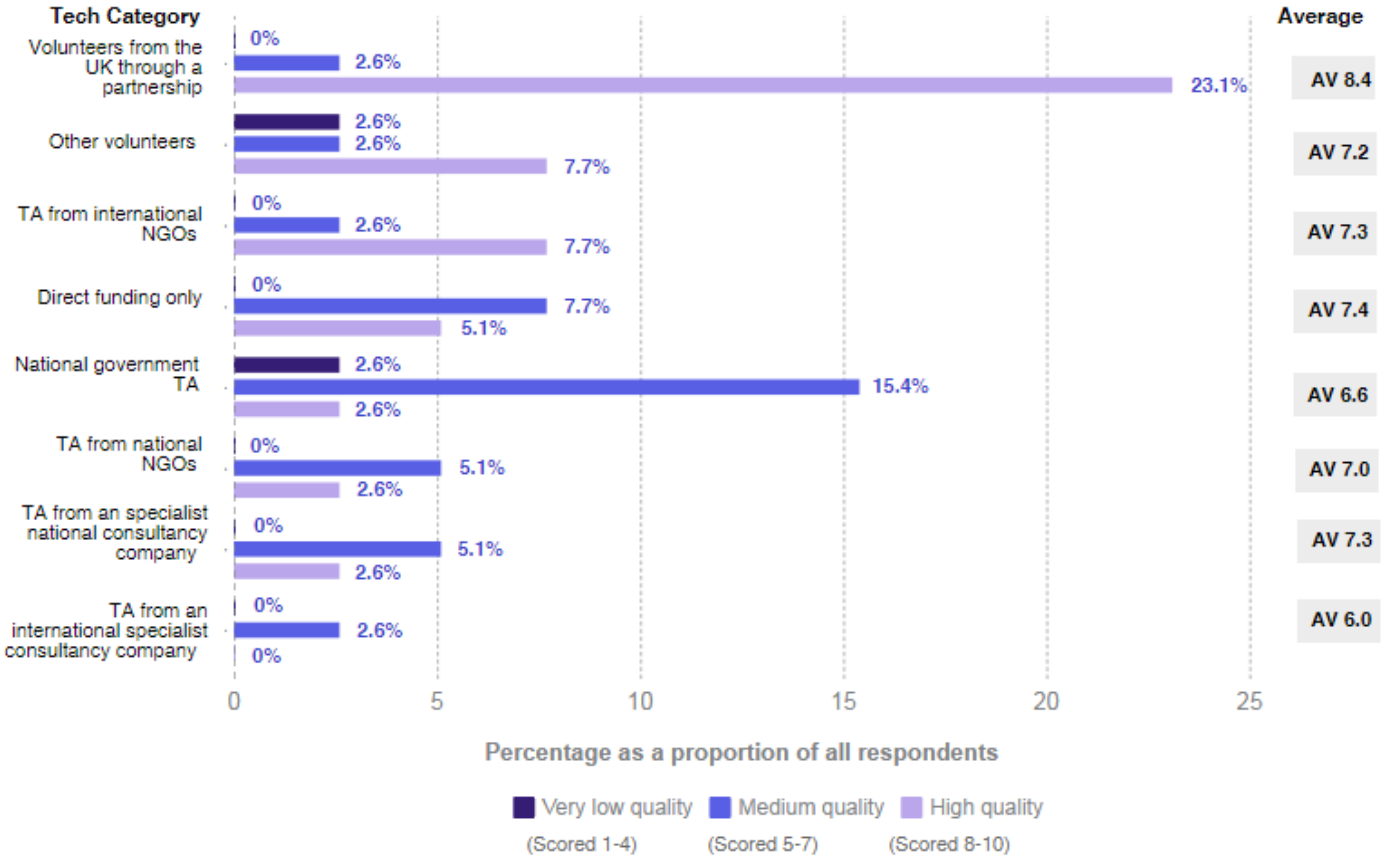


We asked whether there were any specific characteristics that make the support from volunteers more effective than other types of support. Characteristics included:

- **The nature of support provided (mentorship, practical, one-to-one support):** *"One on one coaching and ability to seek clarifications. Practical demonstrations and direct involvement of volunteers in activities with our staff," "Those who are skilled mentors*," and *"Multidisciplinary, multi-tasking, leadership, mentoring are vital."*
- **Adaptability, cultural sensitivity and exposure to similar settings:** "Those who have worked in Africa before," and "*Volunteers need to be culturally sensitive and adaptable. Volunteers need to develop a good relationship and understanding with the local partner."*
- **The nature of the partnership itself:** "*The long-term relationships we have built up over the years with our colleagues from Chester ensure mutual trust and respect so constructive criticisms can be offered and welcomed in both directions. This has led to a more mature understanding of the real challenges and issues and a shared partnership approach to moving forward."*

The following graph demonstrates how respondents rated the different types of technical assistance they had received in the last 3 years. Receiving volunteers from the UK through a partnership was rated as being the highest quality input, followed by other volunteer input and technical assistance from international NGOs. Technical assistance from consultancy companies (national and international) were ranked lowest.

Figure 42: Quality of different types of Technical Assistance received over the last three years



When asked to outline any challenges experienced in terms of support received from UK volunteers, responses included challenges relating to:

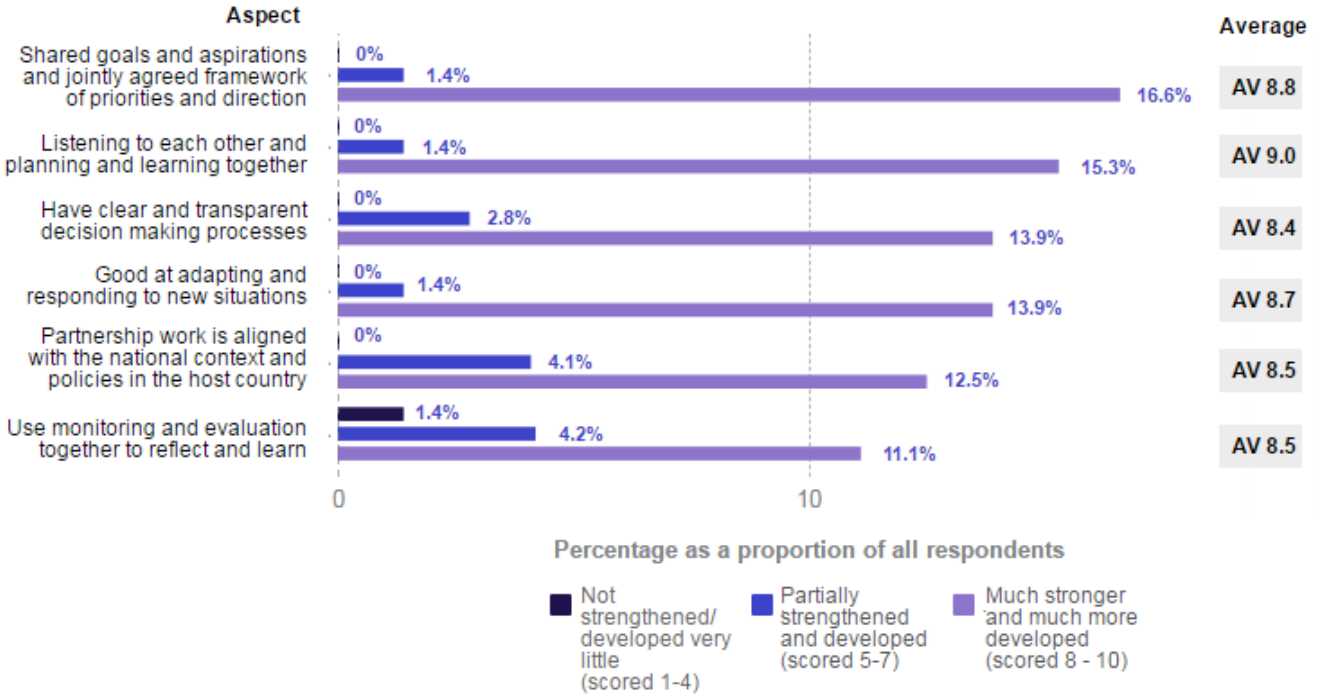
- **Incorrect 'pitching' of the level of training provided:** *"Some of the concepts introduced by the volunteers were hard to grasp by the midwives despite the high quality of the content they were receiving."*
- **Lack of exposure to or understanding of the context: "***A couple of volunteers were not well qualified to train Nepali health workers in the rural context," and "In the first years of the partnership the volunteers had less insight into the challenges of working in a rural hard-to-reach location with very poor communities and limited resources but as the partnership developed and matured they now understand much more the issues Kisiizi faces. Initially there was frustration if progress seemed slow but now there is a more realistic recognition of the big picture and how the project fits into a wider agenda of work by Kisiizi and how by persistence and determination good outcomes are achieved."*
- **Length of visits:** *"Initially short visits were not effective, now visits last up to two weeks and results are clearly shown to improve."*

Five of the 11 respondents stated there were no challenges.

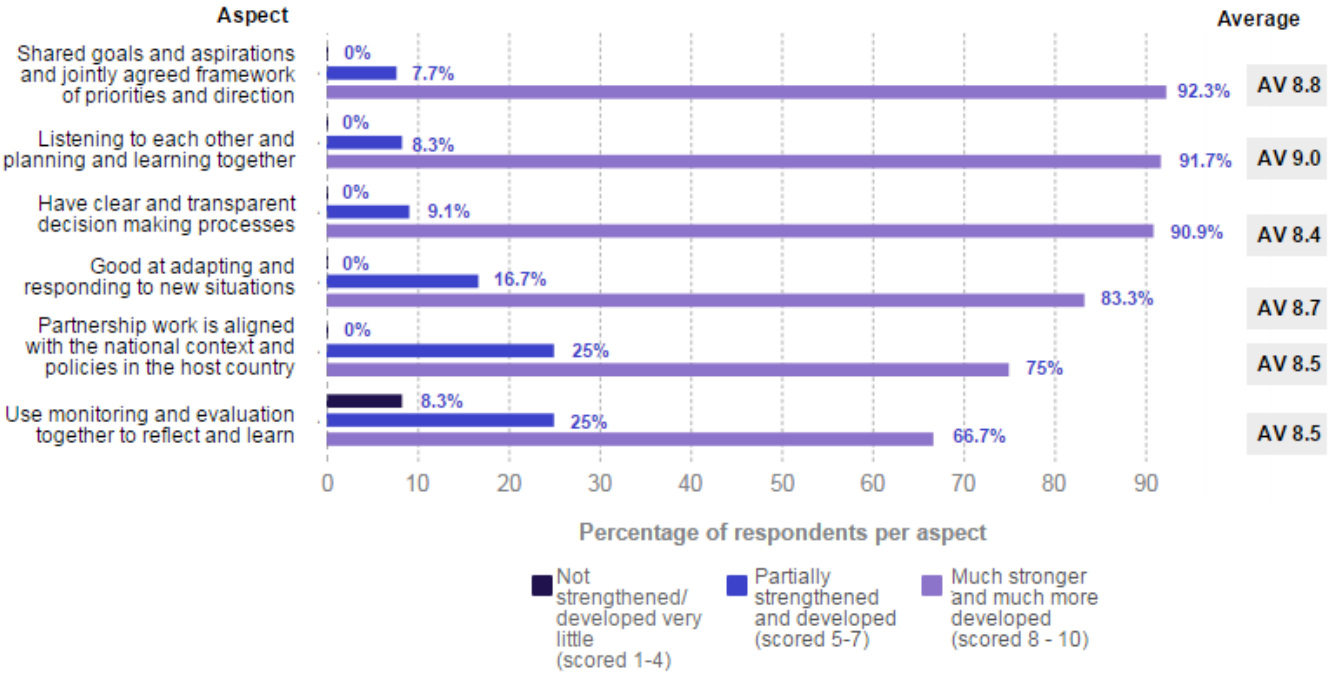
Changes in the partnership:

The graph below demonstrates the extent that specific aspects of the partnership strengthened as a result of the HPS project. Having shared goals, listening to each other, having clear and transparent decision making processes and adaptability to new situations were rated most highly in terms of the proportion of all respondents who rated these partnership attributes as significantly developed and stronger as a result of the HPS project.

Figure 43: Extent that specific aspects of the partnership strengthened as a result of the HPS project



The graph below presents the same data, but with the percentages presented as a proportion per category or partnership aspect (as opposed to proportion of all respondents).



HPS Project Effectiveness:

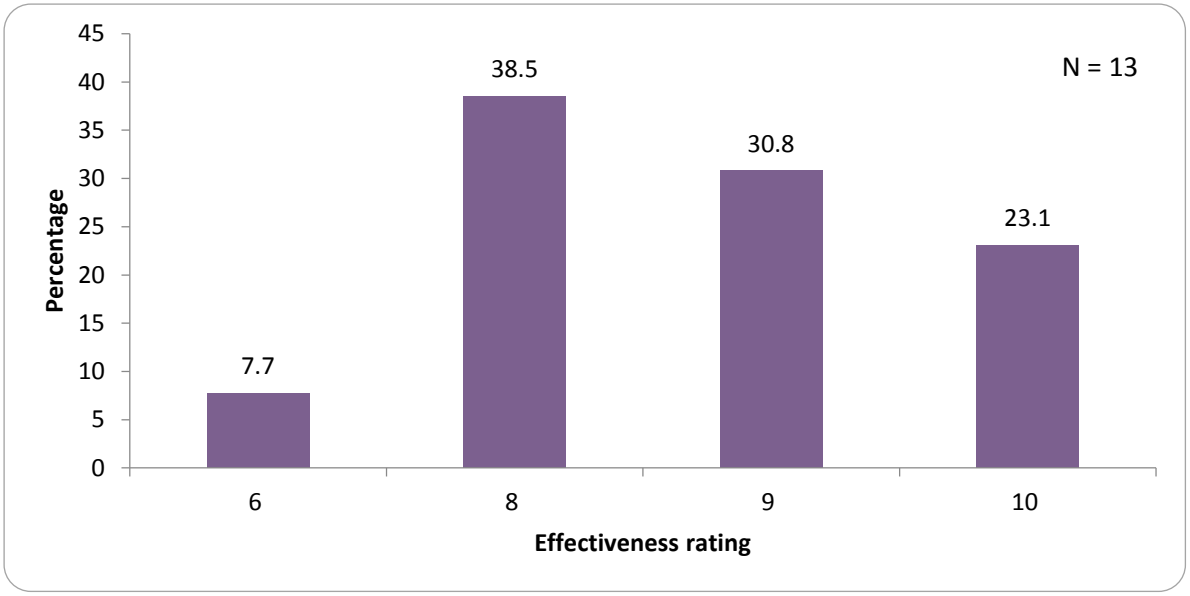
When asked to rate the effectiveness of their HPS project in **strengthening the capacity of the health workforce** (on a scale of 1-10, where 1 was not effective at all and 10 was very effective), respondents rated this quite highly - with a score of '8' as the median value (and cited by 39% (n=5) of respondents). A total of 54% (n=7) rated their project as 9 or 10 i.e. very effective in strengthening the capacity of the overseas health workforce.

Some qualitative examples of the ways respondents thought this had occurred include:

"Very effective. The project has trained more than a thousand health care professionals in all 14 districts of Sierra Leone," and

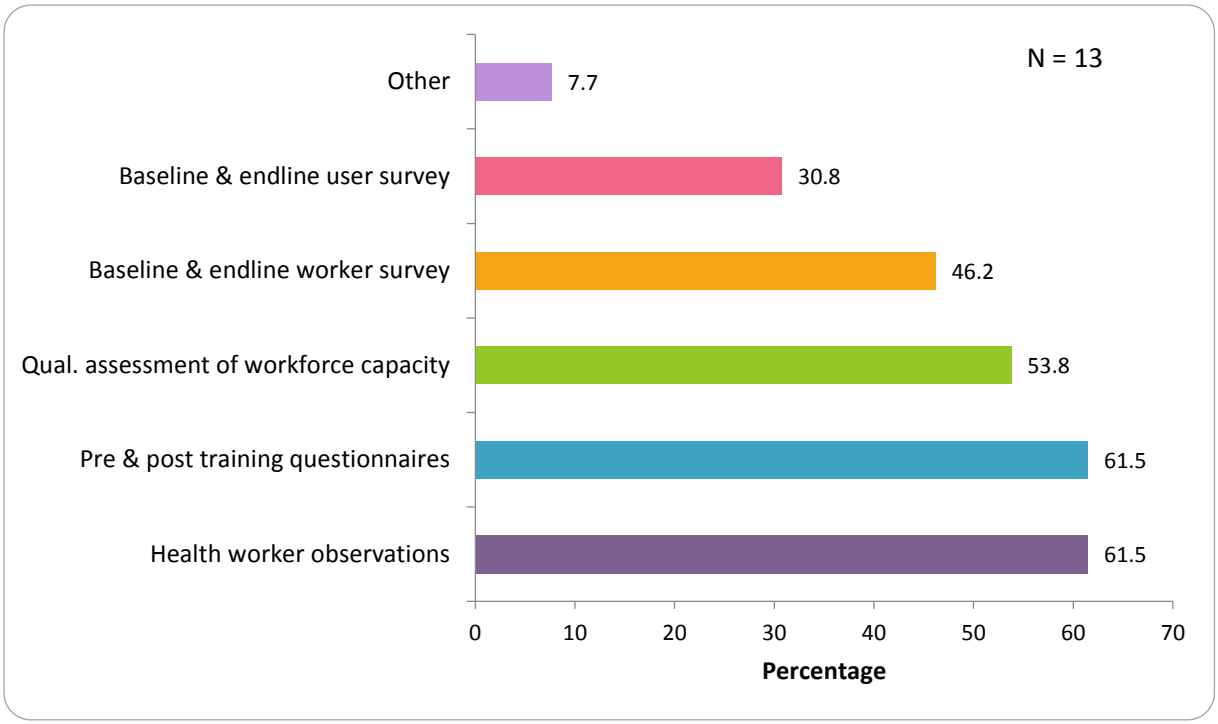
"The whole project was about empowering the health workers to manage their quality of care issues locally."

Figure 44: Effectiveness of HPS project in strengthening the capacity of the health workforce



To support their view of the project's effectiveness on strengthening the workforce capacity, a large proportion of respondents referred to observations of health workers (62%; n=8) and pre- and post- training questionnaires (62%; n=8). Baseline and endline assessments were cited by 46% (n=6) of respondents.

Figure 45: Evidence to support views of project's effect on health workforce capacity



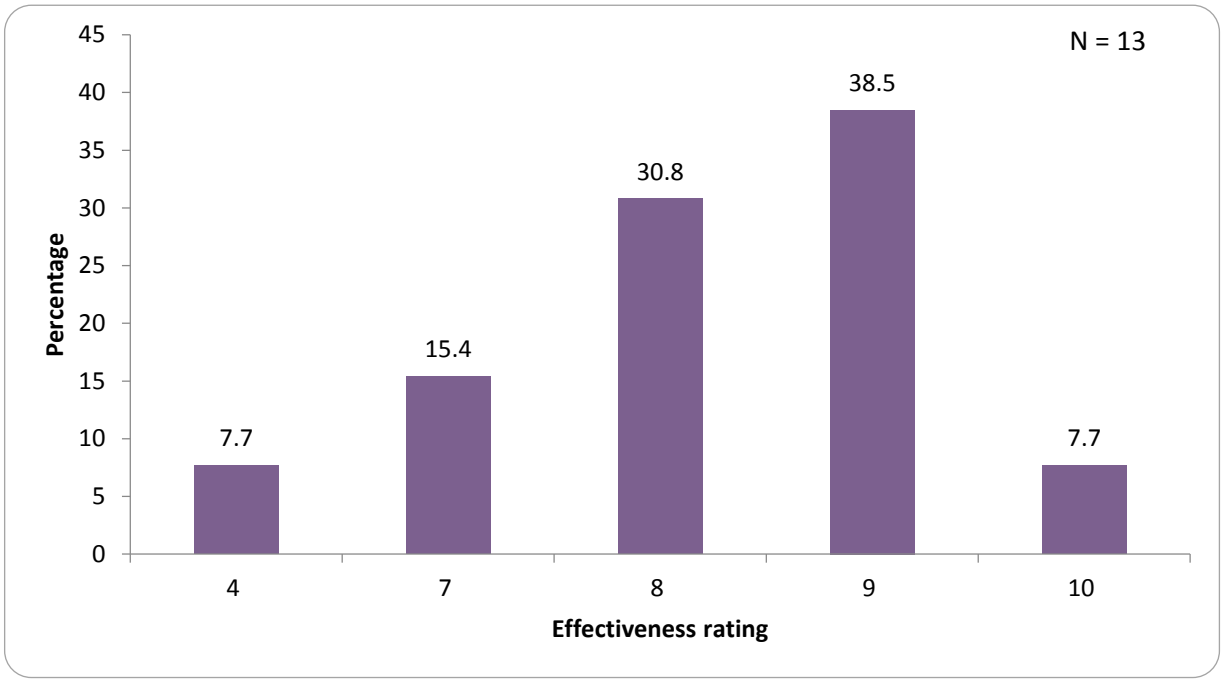
When asked to rate the effectiveness of their HPS project in strengthening the **institutional capacity of their organisation** (on a scale of 1-10, where 1 was not effective at all and 10 was very effective), again respondents rated this highly - with a score of '8' as the median value (and cited by 31% (n=4) of respondents). A total of 47% (n=6) rated their project as 9 or 10 i.e. very effective in strengthening the capacity of their organisation.

Some qualitative examples of the ways respondents thought this occurred include:

"Our institution has adopted the ETAT programme and institutionalised it," and

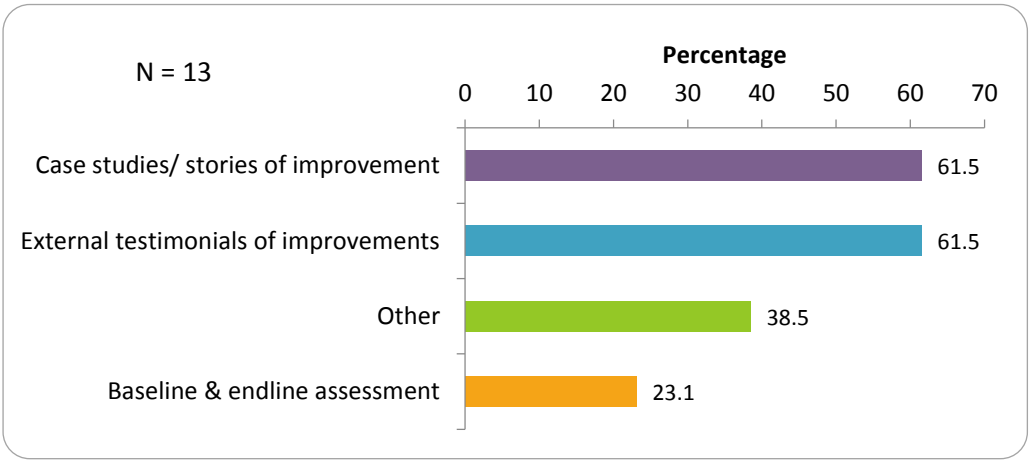
"UPMA has gained more recognition among partner health organizations in Uganda. Moreover, this has called for the formulation of midwifery mentorship standards in Uganda."

Figure 46: Effectiveness of HPS project in strengthening the institutional capacity of organisation



To support their view of the project's effectiveness on strengthening their institutional capacity, qualitative case studies or stories and external testimonials of improvements were most commonly cited (both 62%; n=8).

Figure 47: Evidence to support views of the project's effect on institutional capacity



When asked whether there was any evidence of attitudinal or behavioural changes around **gender equality** in their organisation or amongst health workers, 54% (n=7) stated no.

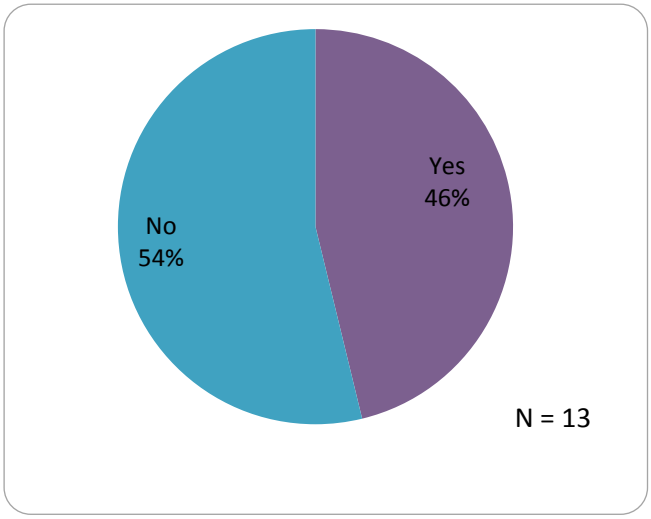
Comments to illustrate this included:

"No particular issues or problems relating to gender equality were present before the HPS project," and

"The project had no aspect related to promotion of gender equality. Males and females had equal chances and opportunities to benefit from the projects teachings and other opportunities",

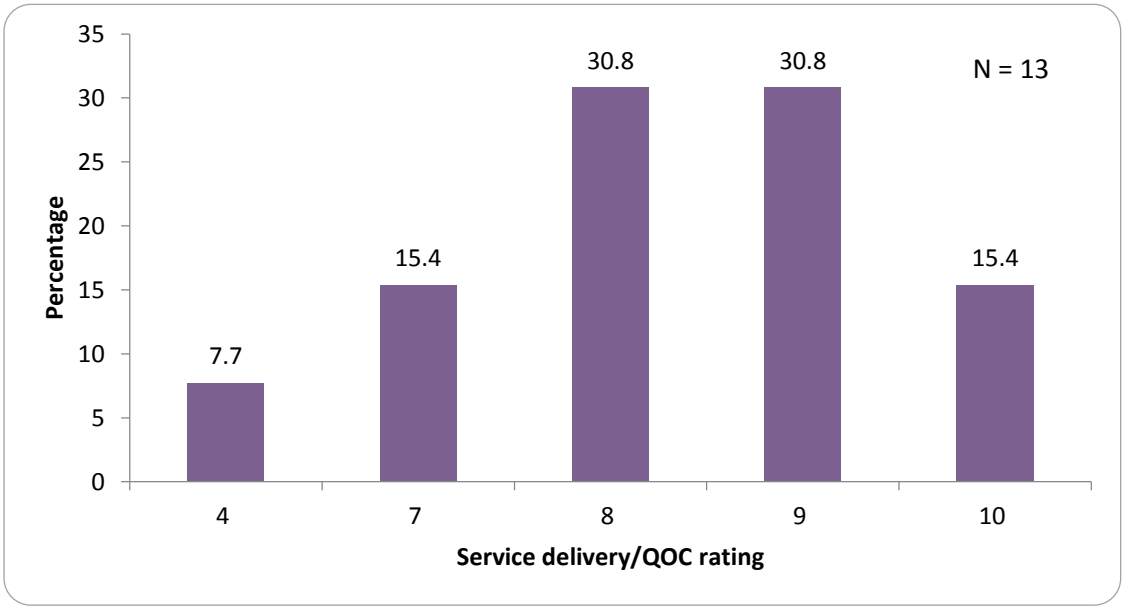
Although one respondent did state: *"Our female staff are now more empowered."*

Figure 48: Evidence of changes in attitudes/ behaviour gender equality



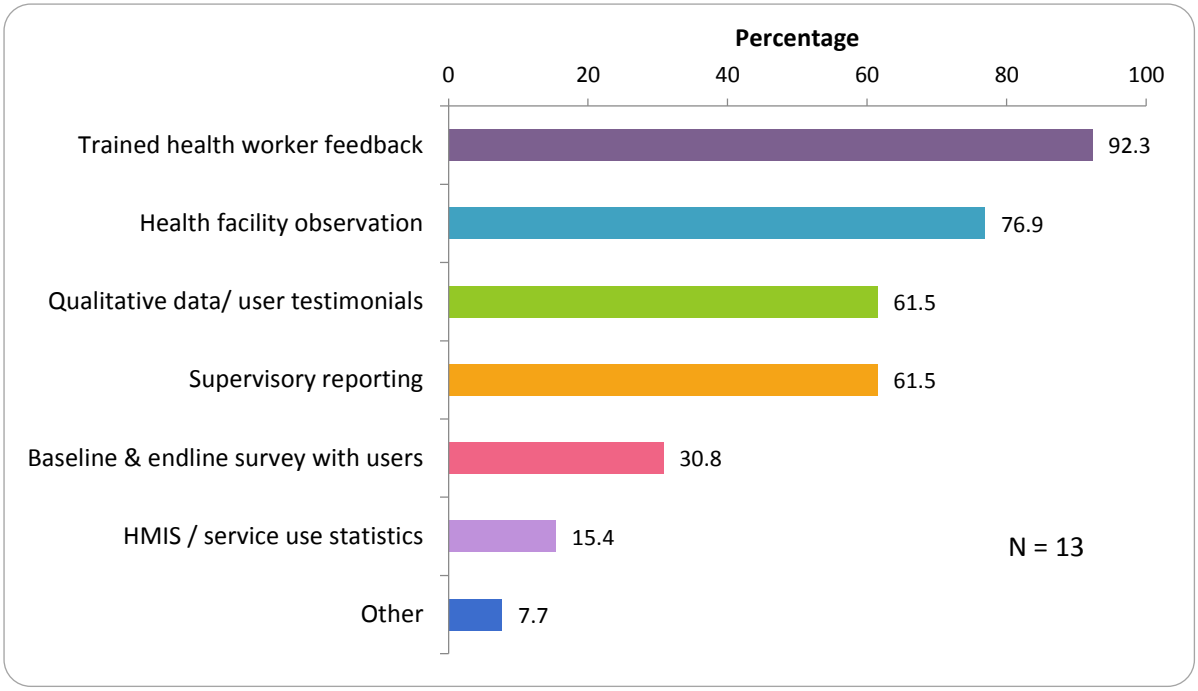
When asked to rate the **change in delivery of services and quality of care** resulting from their HPS project, (on a scale of 1-10, where 1 was no improvement at all and 10 was a significant improvement), again respondents rated this highly - with a score of '8' as the median value (and cited by 31% (n=4) of respondents. A total of 46% (n=6) rated their project as 9 or 10 i.e. very effective in strengthening the capacity of their organisation.

Figure 49: Change in delivery of services and quality of care that resulted from HPS project



Lastly, when asked about evidence to support these views, the majority of respondents referred to feedback from trained health workers (92%; n=12) and health facility observations (77%; n=10). 31% (n=4) respondents conducted baseline and endline surveys with health service users to assess quality of care, and only 2 respondents referred to HMIS or service use statistics.

Figure 50: Evidence to support views on improvements in service delivery and quality of care



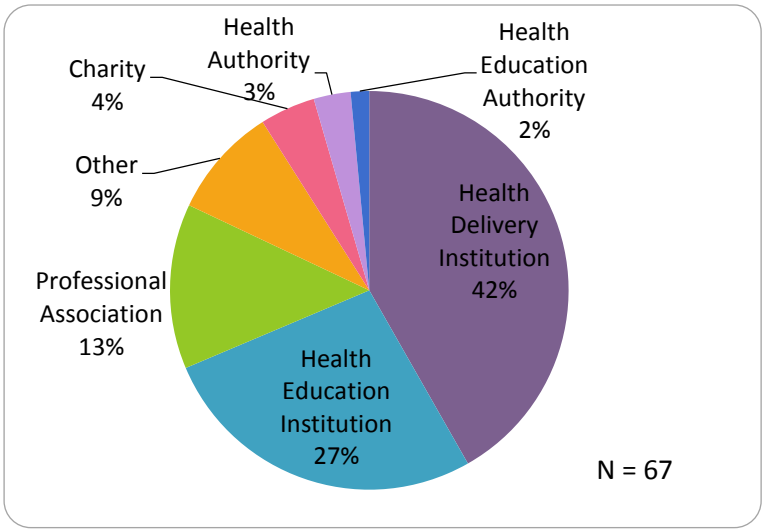
9.3 UK Partner Survey – Report

After data cleaning there were a total of 67 valid responses to the UK partner survey. Note that some questions were not completed by all respondents, thus 'n' varies for a number of questions. Note that 1 response does not necessarily equate to 1 project - as some projects may be undertaken by multiple partners who have responded to the survey. These responses have not been excluded in the sample of respondents to maximise the sample size. Also note that for a number of the survey questions, respondents were able to tick more than one response, meaning that the total % often adds up to more than 100%. Lastly, please note that this report does not include analysis of all the qualitative responses as these have been analysed separately using NVIVO – instead highlights are provided.

Basic respondent demographics – partner profile:

Individuals from a variety of UK organisations responded to the survey. 42% were from health delivery institutions, 27% were from health education institutions and 13% were from professional associations.

Figure 51: UK organisation type

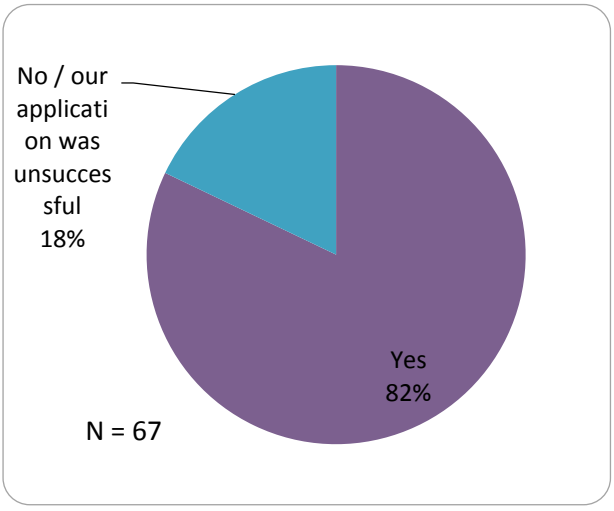


Project profile:

Of the 67 survey respondents, 18% (n=13) were unsuccessful in their application for HPS funding. Of these, 33% (n=4) went on to find funding for their project elsewhere but the majority (67%; n=8) were unable to source funding for the project.

The remaining 82% of the survey respondents (n=55) were awarded an HPS grant. 17 respondents had completed projects and the remainder were implementing ongoing projects at the time of completing the survey.

Figure 52: Successful applications/ funding recipients

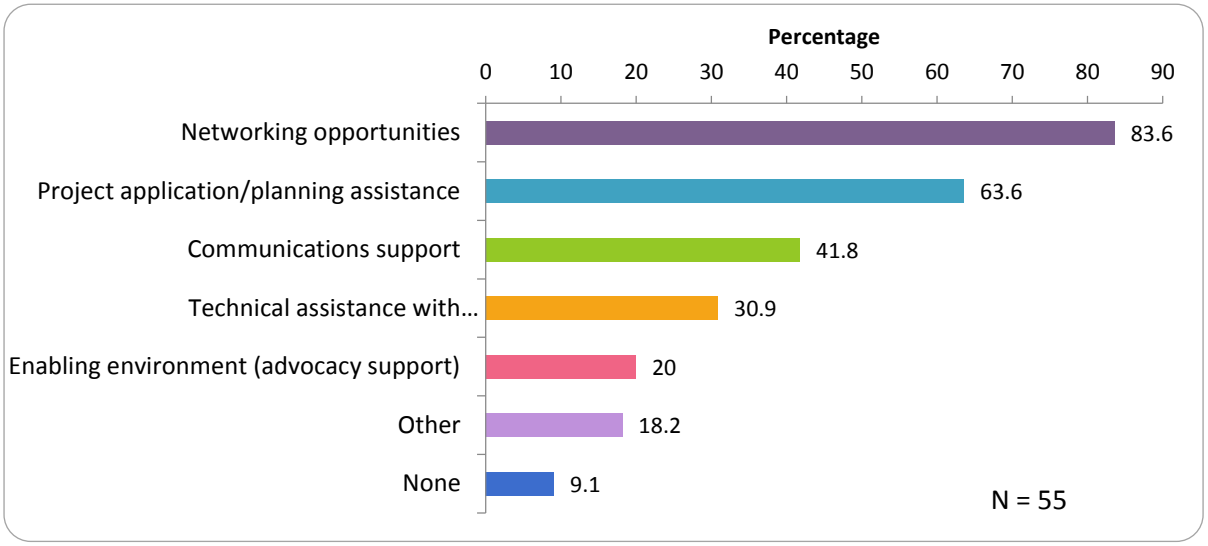


HPS funding recipients:

36 respondents responded to the question about their project budget. Projects varied in size, with budgets ranging from £3,000 to £735,850. The average (mean) project budget was £123,463.

When asked what other benefits or types of assistance applicants and grantees received from HPS (in addition to grant funds), responses included networking opportunities (84%; n=46); assistance with project application and planning (64%; n=35); communications support (42%; n=23) and technical assistance with implementation (31%; n=17). Advocacy for a better NHS and institutional volunteering policy (enabling environment) was only cited by 20% of respondents (n=11). 9% (n=5) respondents did not feel they received any other form of support from the HPS beyond direct funding. Options in the 'other' category included 'information support and advice', 'shared learning' and 'suggestions regarding publications.'

Figure 53: Type of support received from HPS

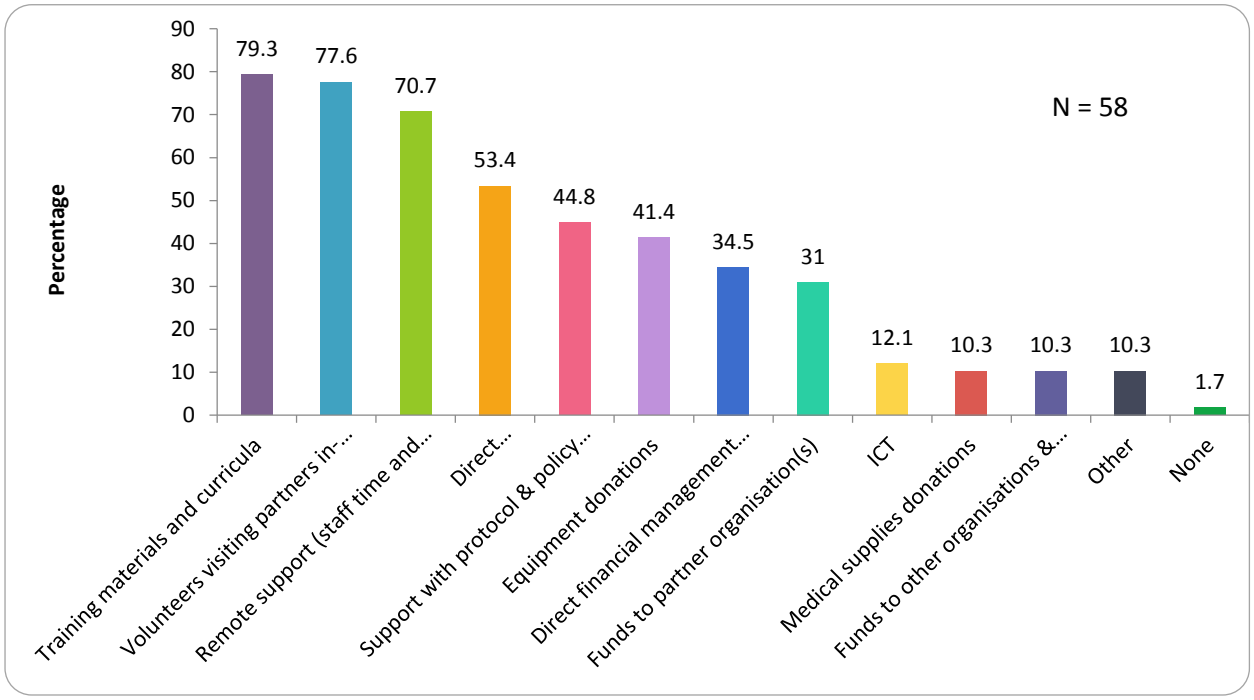


Partner inputs:

When asked about the main inputs of their organisation into the project, 78% (n=45) of respondents stated 'provision of support sending volunteers overseas'. Of these 45 organisations that sent volunteers overseas, 38% (n=17) were health delivery institutions and 27% (n=12) were health education institutions.

79% (n=46) of respondents stated that their organisation has provided training materials and curricula. 71% (n=41) had provided remote support in terms of staff time and expertise, and 53% (n=31) had provided direct systems, strategy or planning support to overseas organisations. 'Other' options included support with protocols and policies (45%), donation of equipment (41%) and direct financial management support (35%).

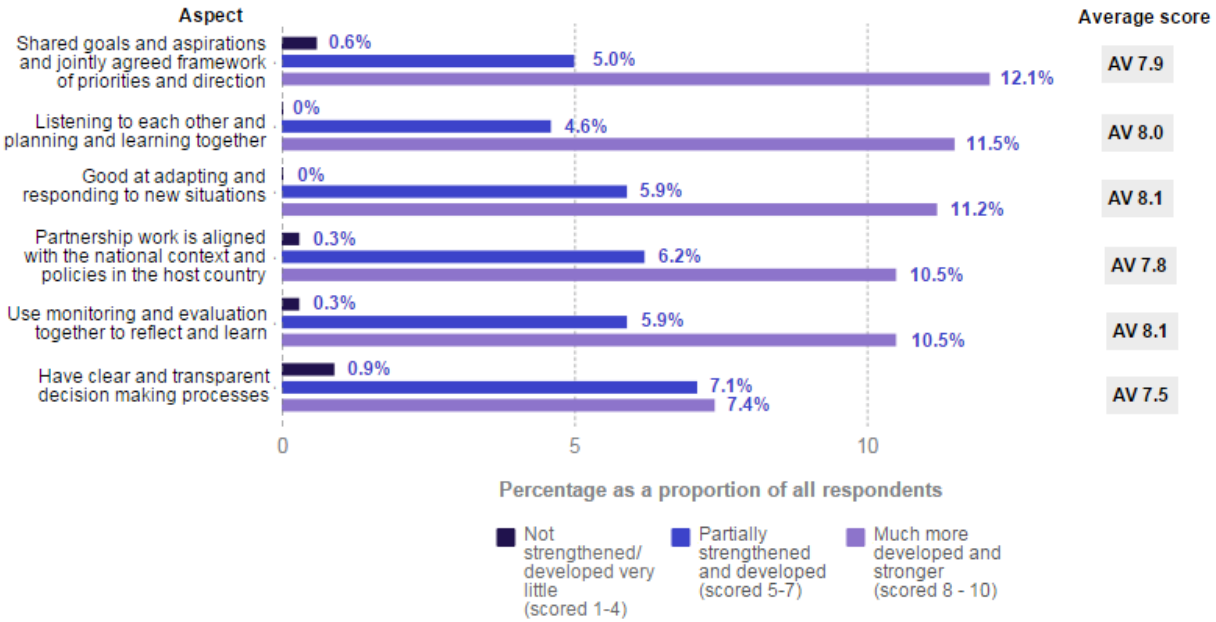
Figure 54: Main organisational inputs into the project



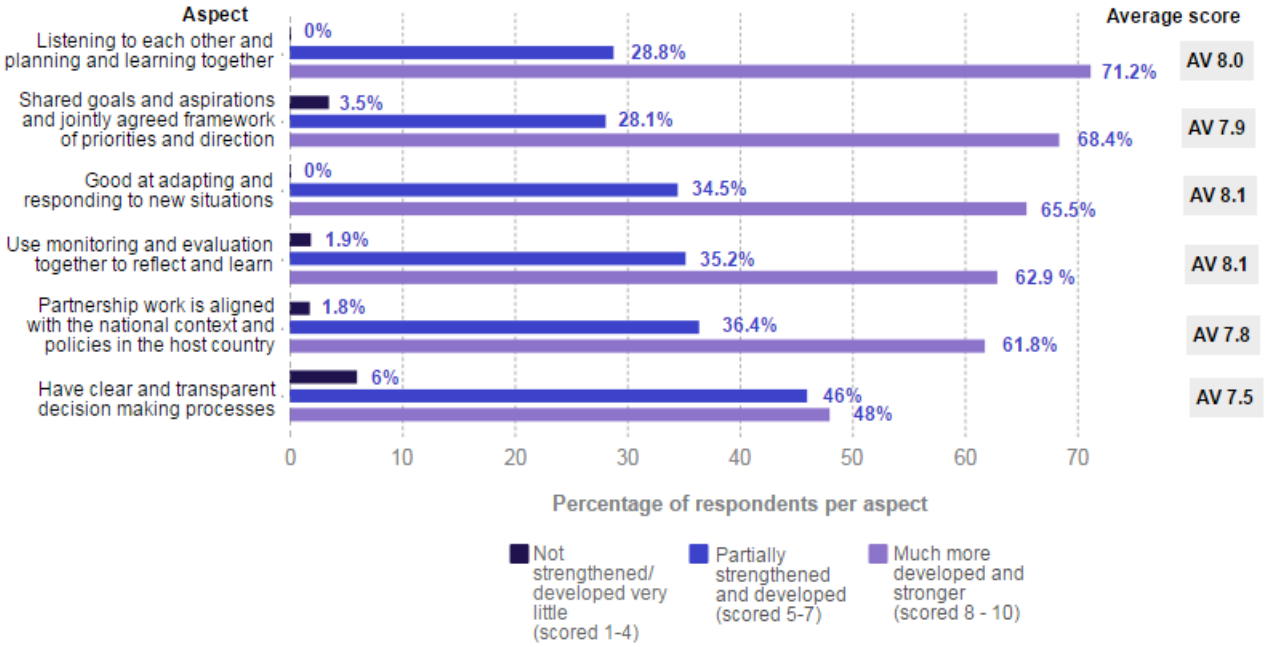
Of the 17 respondents whose organisations had completed projects at the time of filling out the survey, nearly three-quarters (71%; n=12) had continued to provide support to the overseas partner organisation after the end of the project. Support included continued communication, support on new grant proposals or fundraising, ongoing technical support in terms of visits, reviewing guidelines or reports and follow on HPS funded projects.

The graph below demonstrates the extent to which different aspects of the partnership have been strengthened as a result of the project. Having shared goals and aspirations, listening to each other, and adapting and responding to new situations were rated most highly – in terms of the proportion of respondents (as a percentage of all respondents to this question) who felt these 'significantly developed and stronger'

Figure 55: Extent that different aspects of the partnership have strengthened as a result of the project



The graph below presents the same data, but with the percentages presented as a proportion per category or partnership aspect (as opposed to proportion of all respondents).



When asked to what extent respondents agreed with specific statements regarding THET's involvement in the partnership, 76% (n=41) felt that THET had provided inspirational leadership to encourage good partnership working, and 82% (n=44) felt that the HPS Principles of Partnership had been a useful guide to partnership working and effectiveness. Only 9% (n=5) and 75 (n=4) of respondents disagreed with these statements respectively. A smaller proportion (65%; n=35) agreed that THET networking and communications support had been crucial to their partnership building, and 19% (n=10) actively disagreed with this statement. 37% (n=20) felt that THET helped to resolve challenges with their southern partner, but a greater number (39%; n=21) felt this was not applicable, suggesting they had not experienced challenges with their partner.

Figure 56: Opinions regarding THET's involvement in the partnership

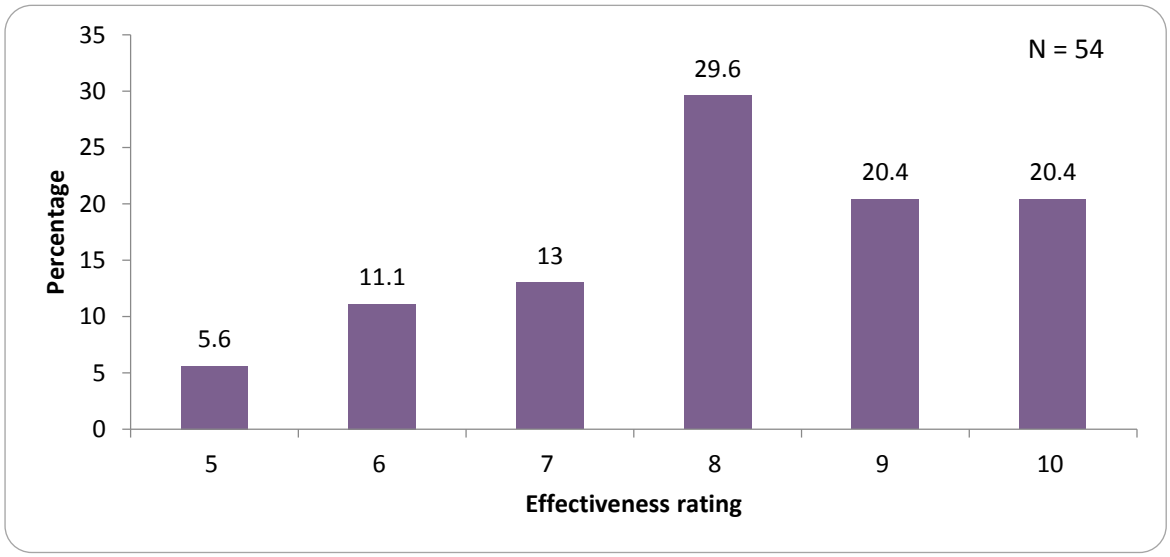
	Agree	Disagree	Don't know	Not applicable
THET has provided inspirational leadership to encourage good partnership working	75.9% 41	9.3% 5	11.1% 6	3.7% 2
The HPS Principles of Partnership have guided us on better partnership working and more effective projects	81.5% 44	7.4% 4	11.1% 6	0% 0
THET has helped us to sort out challenges or differences with our southern partner(s)	37% 20	13% 7	11.1% 6	38.9% 21
THET networking and communications support has been crucial to the building and development of our partnership	64.8% 35	18.5% 10	9.3% 5	7.4% 4

Project effectiveness:

When asked to rate the effectiveness of their project in strengthening the capacity of the **overseas health workforce** (on a scale of 1-10, where 1 was not effective at all and 10 was very effective), respondents rated this quite highly - with a score of '8' as the both the mean and median value (and cited by 29% (n=16) of respondents). A total of 41% (n=22) rated their project as 9 or 10 i.e. very effective in strengthening the capacity of the overseas health workforce.

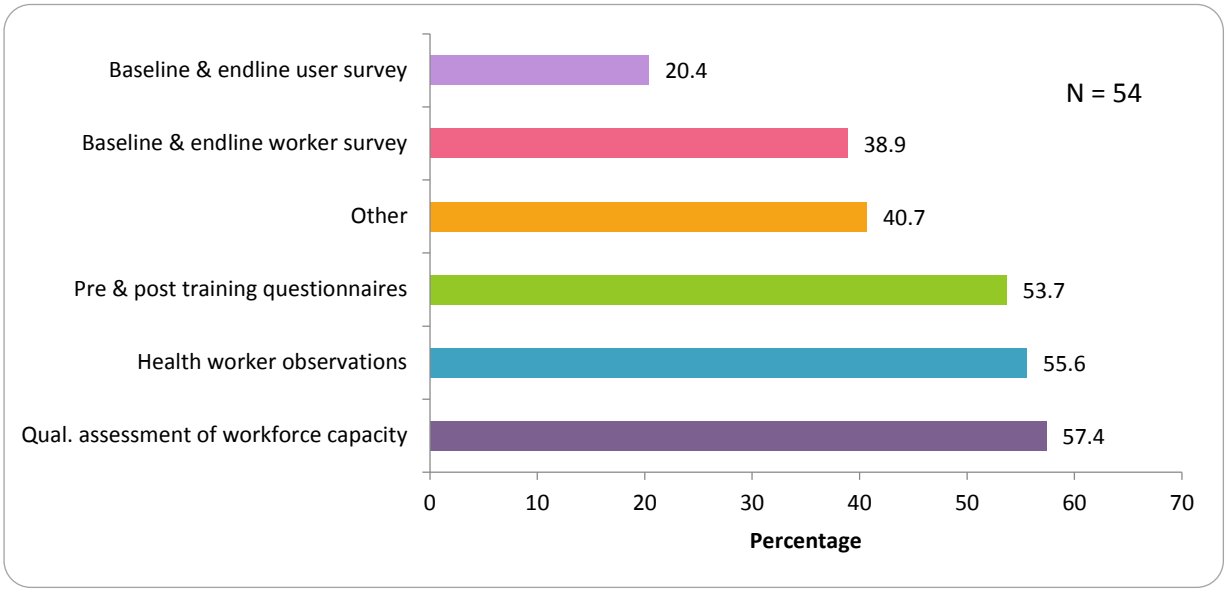
Some examples of the ways in which respondents felt this had occurred were: "*By 2017 there will be over 100 nurses that have qualified as paediatric nurses and who are working in Zambia before the project here was less than 5," "Establishment of a Vision Centre in the Eye Department of the KBTH; transfer of surgical skills to Ophthalmologists in West Africa," "Our work with our partners have brought about policy change to nurse education which should have an impact on a better trained and retaining the trained workforce," "The project is embedded around improved midwifery skills through mentorship of midwives and student midwives. This has been discovered to be an important component to the nursing and midwifery education and has been an advocate for mentorship activities in the Ministry of Health Uganda as well as the midwifery health workforce among private midwives to improve on maternal health. Moreover, this project has advocated for the creation of standard guidelines for nursing and midwifery mentorship by the Nurses and Midwives council in Uganda,"* and *"The partnership has helped strengthen paediatric anaesthesia networks in East Africa (e.g. Ethiopian anaesthetists requesting training in Uganda and Kenya; Ugandan anaesthetists working with Kenyan partners to deliver training; Malawian doctors training in paediatric anaesthesia in Kenya). However, there remains an extreme shortage of anaesthesia providers in all partner countries that needs to be addressed at national level."*

Figure 57: Effectiveness of HPS project in strengthening capacity of health workforce overseas



When asked what evidence they had to support their views on the project's effectiveness in strengthening the overseas health workforce capacity, qualitative assessments and observations were the most commonly cited sources (57%; n=31 and 56%; n=30 respectively). 54% (n=29) of respondents stated that the project had used pre- and post- training questionnaires to assess changes in health worker capacity. Fewer respondents used a baseline and endline survey with health workers (39%; n=21) or health service users (20%; n=11). Options in the 'other' category included personal feedback, an MSc thesis, clinical audits, policy change and interviews with wider stakeholders including MOH.

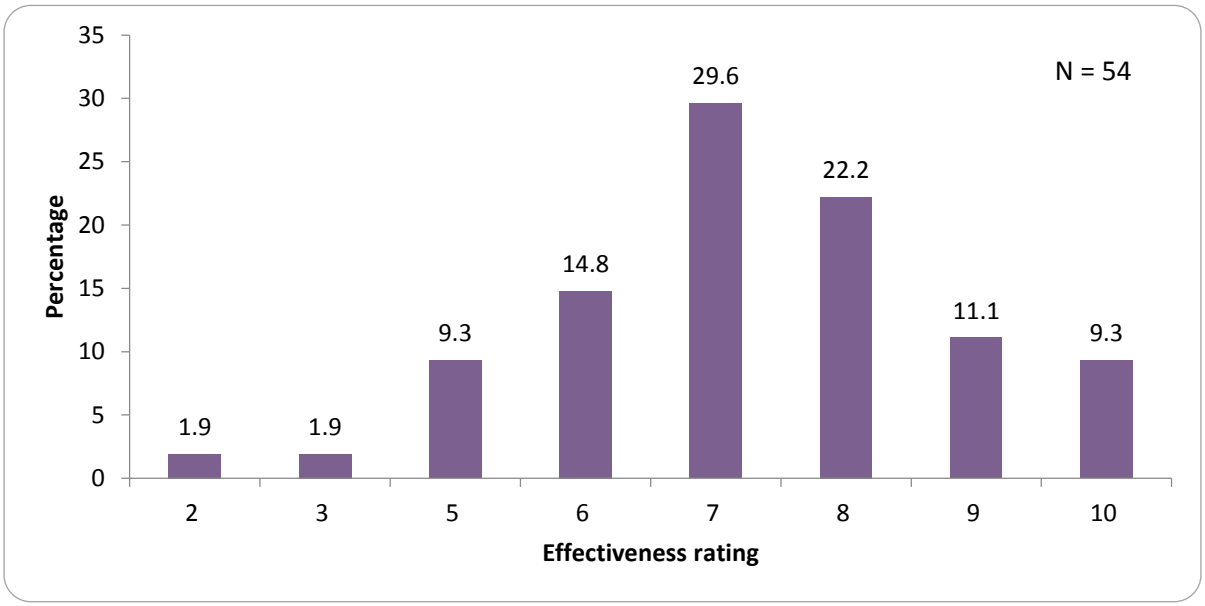
Figure 58: Evidence to support views on project's effect on health workforce capacity overseas



When asked to rate the effectiveness of their project in strengthening the capacity of the **overseas partner institution** (on a scale of 1-10, where 1 was not effective at all and 10 was very effective), respondents rated this slightly less highly than the previous question (re. impact on health workforce) - with a score of '7' as both the mean and median value (and cited by 30% (n=16) of respondents). 20% (n=11) of respondents felt that their project was very effective (a score of 9 or 10) in strengthening the institutional capacity of their overseas partner.

Some examples of the ways in which respondents felt this had occurred were: *"The Management of Surgical Emergencies Course has been run twice by trained trainers in Zambia with a further MSE [course] to be undertaken this autumn in Zambia and probably also in Kenya,"* and "*The project has provided more linkages in terms of communication and networking among anaesthetic providers".*

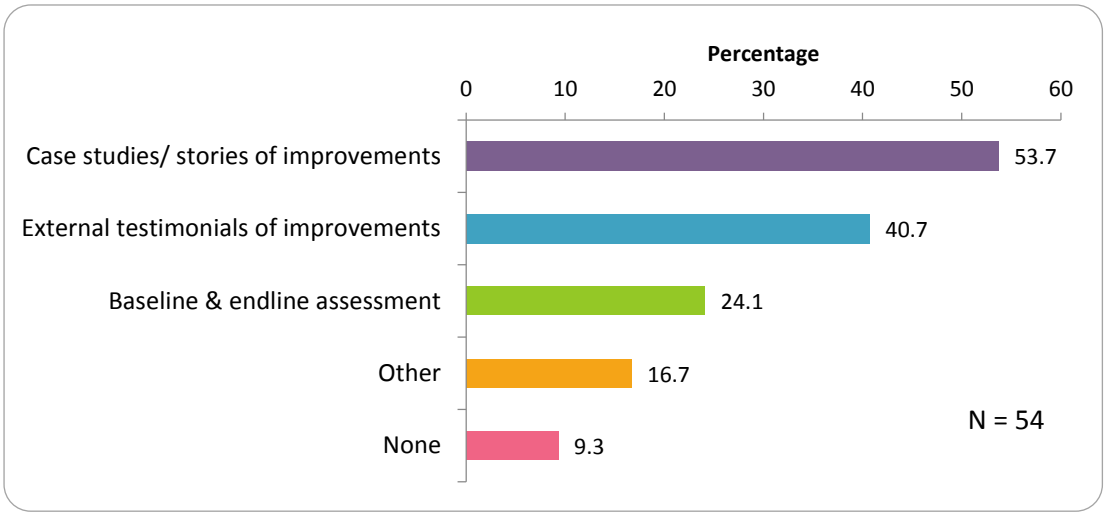
Figure 59: Effectiveness of HPS project in strengthening capacity of the partner organisation overseas



To support their view of the project's effectiveness on strengthening partner institution capacity, again, the majority of respondents referred to qualitative case studies or stories (54%, n=29) and external testimonials

of institutional capacity improvements (41%; n=22) as sources of evidence. Institutional baseline and endline assessments were cited by 24% (n=13) of respondents.

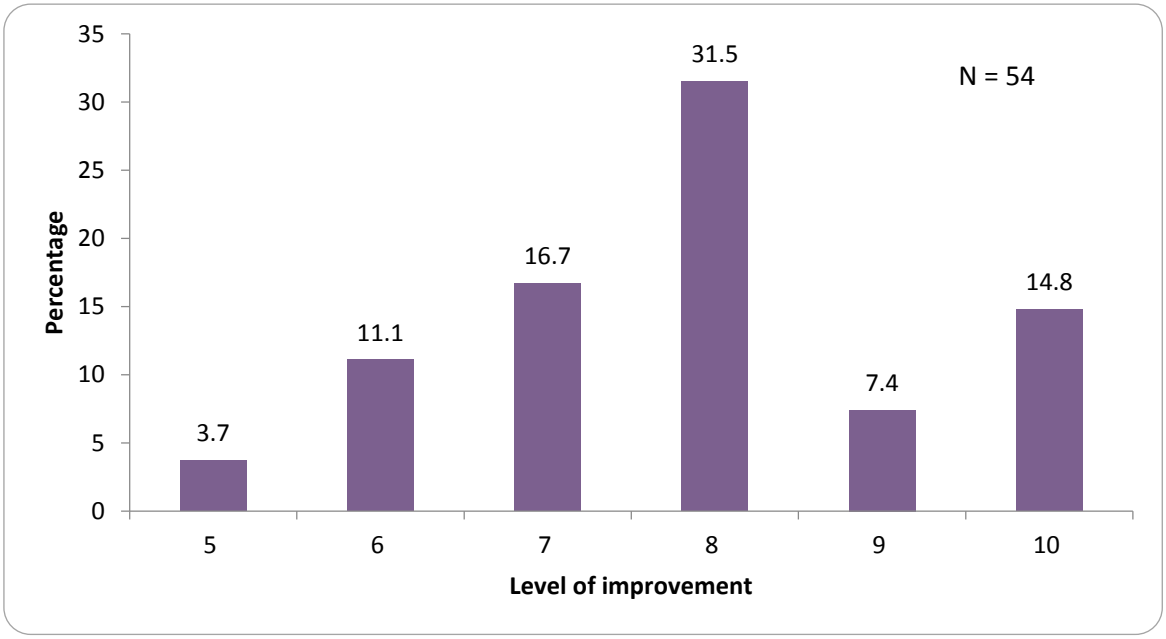
Figure 60: Evidence to support views of project's effect on partner institutional capacity



When asked whether there was any evidence of improved attitudes and behaviour around gender equality in the partner organisations, or among health workers, as a result of the project, 59% (n=32) respondents said no, and only 41% (n=22) said yes. When asked to provide further comment about this, many of the respondents stated that gender equality was not a focus of the project, that it wasn't a problem or that this wasn't assessed by the project. However, an example of positive change cited was: "*The workforce we are training is completely female. We have helped them to start discussions about mental well-being with husbands of the women they looked after in childbirth. Not a great shift in gender relationship but a step towards empowerment in a very patriarchal society in rural Nepal."*

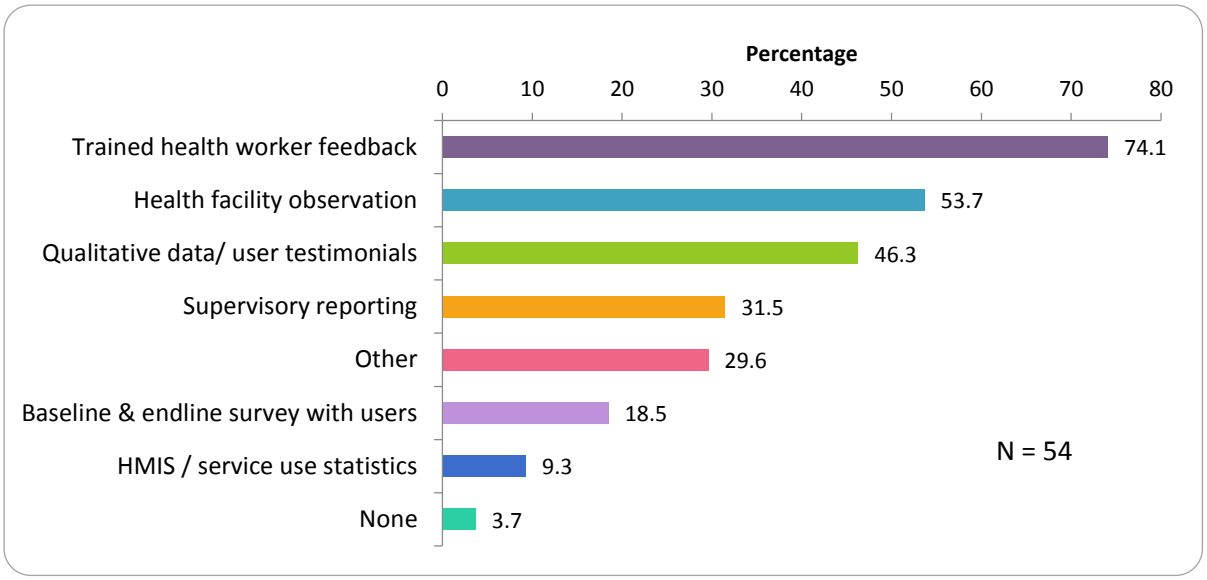
When asked to rate the change in delivery of services and quality of care that resulted from the project (on a scale of 1-10 where 1 was no improvement and 10 was significant improvement), a score of '8' was the median (and mean) value given (and cited by 32% (n=17) of respondents). Eight of the 54 respondents who replied to this question stated that this question was 'n/a' to them or their project.

Figure 61: Change in delivery of services and quality of care that resulted from project



Evidence to support these views on improvements in service delivery and quality of care included feedback from trained health workers (74%; n=40); observation in health facilities (54%; n=29) and qualitative data and service user testimonials (32%; n=17). Baseline and endline surveys with health service users were cited by 19% (n=10) of respondents, and only 9% (n=5) referred to HMIS or service use statistics. Options in the 'other' category included case note audits, laboratory accreditation ratings and 'to be evaluated in final evaluation'.

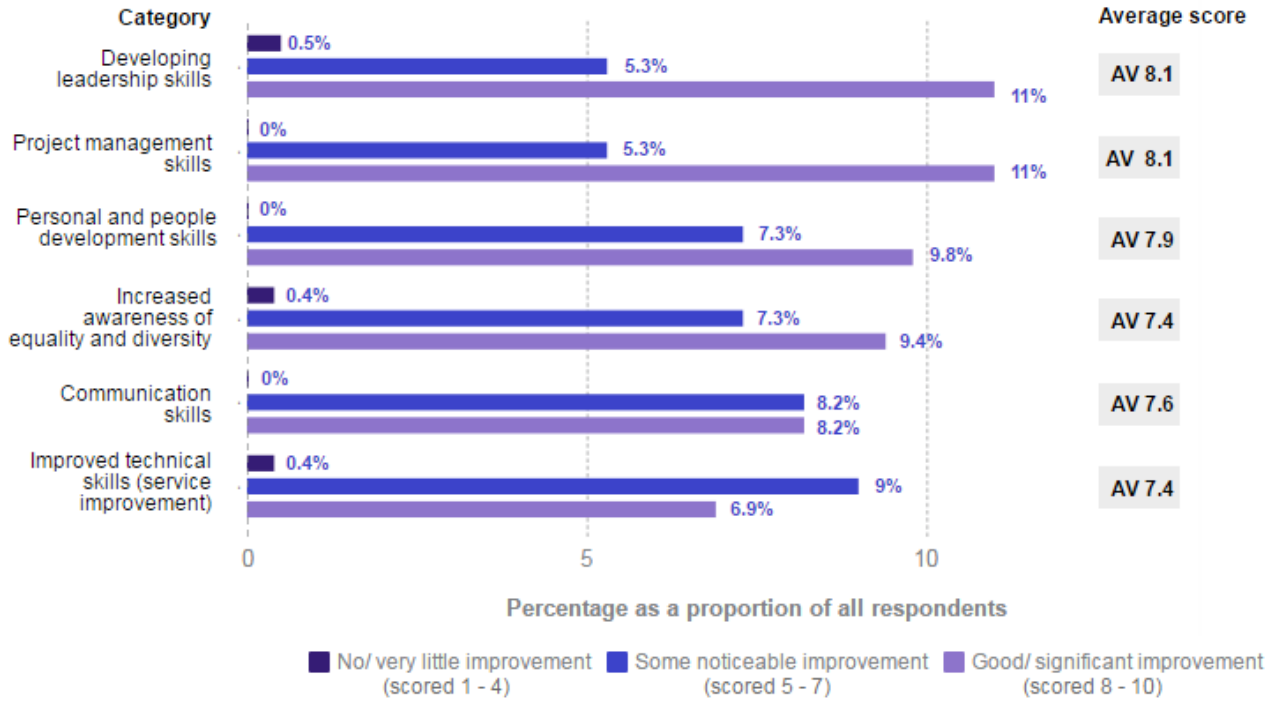
Figure 62: Evidence to support views on improvements in service delivery and quality of care



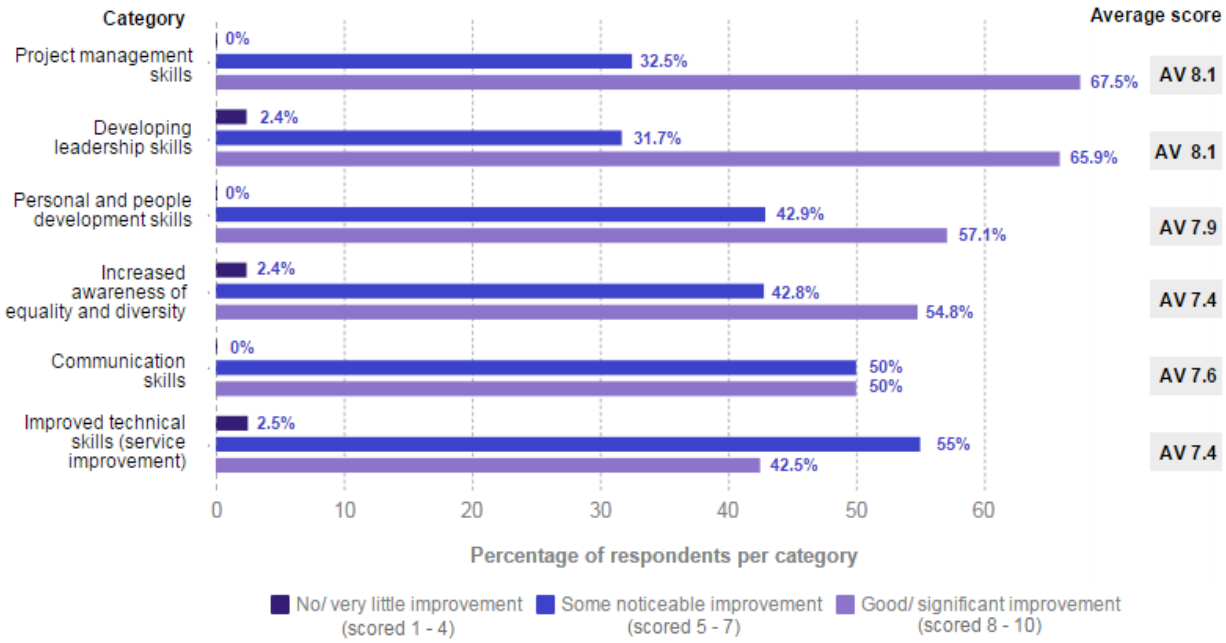
Benefits for UK partner:

The graph below demonstrates the extent that respondents felt that different skills of volunteers have improved as a result of their volunteering experience overseas. The development of leadership skills was rated most highly, followed by improved project management skills – in terms of the proportion of respondents who felt there had been a significant improvement in these skills.

Figure 63: Extent that specific skills of volunteers improved as a result of their volunteering experience overseas



The graph below presents the same data, but with the percentages presented as a proportion per category or skill area (as opposed to proportion of all respondents).



When asked to comment on any other skills that had changed as a result of volunteering overseas, some examples of the responses include:

"In-depth awareness and appreciation of the challenges faced by many of our colleagues in low-income countries of which there are no easy answers. Learning and development in lots of areas is a two-way process but it is vital that these partnerships that have been developed over years are encouraged to continue and thrive,"

"Our volunteers learn Quality Improvement and project planning and management skills. As well as improved abilities in the 9 leadership behaviours identified in the NHS Healthcare Leadership Model (2013),"

"The need to be flexible, respond to unexpected challenges (both clinical and managerial), the opportunity to think differently about challenges and the context, considering how to monitor and evaluate a project are all skills we have continued to develop," and

"Volunteers have developed a long term interest in global health, teaching, training and or research. Volunteers have developed a respect for their colleagues who are delivering healthcare often in very challenging circumstances."

Benefits at the **UK organisational level**: A more detailed analysis of the benefits of HPS for the UK organisation is included elsewhere. However, a few examples from the survey include:

"A broadening of minds in the staff concerned, particularly with regards to the concept of equity in provision of health care and, a stimulus towards being able to achieve more with less,"

"Improved teaching skills and improved staff motivation",

"Raising profile, attracting PhD students, follow-on projects, collaborations, increased skills in M & E,"

"Involvement with HPS has significantly raised the profile of RCPCH's involvement with the wider global health community, and offered excellent opportunities to our members," and

"Volunteers have returned as activists for us, i.e. for their own professional association. It has enabled us to reach out to our members who are working in our target countries and provide them with support. It has been

a staff development opportunity for our own staff. We have been able to retain the position of global projects officer within our staff. It has moved us on greatly in our understanding of our role (and other professional associations) in global health and development. It has increased our reputation and others' confidence in us as a provider of global health programmes. It has enabled us to network more widely and to give many conference presentations, thus getting exposure to new fields. It has strengthened our relationship with DFID and other donors. It has strengthened our links with both UK schools of tropical medicine - as programme director I am now on a programme board for LSTM. Our global work is now a priority across the whole organisation which it was not before."

Similarly, a more detailed analysis of the main **challenges of the UK organisation's participation** in HPS is included elsewhere, but a few examples from the survey include:

- **Practical challenges:** "*Fitting the project into an already very busy schedule," and "communication with our partner due to very poor infrastructure of IT system" and "limited funds",*
- **Challenges with staff having insufficient time/availability to volunteer**: "Releasing staff to visit our overseas partner" and "getting the times the volunteers are available (many NHS staff need to plan leave long in advance),"
- **Reporting challenges:** "*The fact that our programme's focus is on system-development and strengthening, and that we work with multiple projects in more than one partnership has made some of the reporting a bit of a challenge at times,"* as well as
- **More strategic concerns, including:** "*Delivering a complex multi-country, multi-level project within the HPS timescales*," and "*to achieve informed consensus for CPD provision across different areas of clinical practice and across regions at the stakeholder event."*

HPS granting process:

The majority of responses regarding the **HPS grant application process** were positive. More than three quarters (76%; n=45) of respondents felt that information on the website and in HPS materials was easy to use and understand and 86% (n=51) found HPS staff to be helpful and knowledgeable. 78% (n=46) found the grant application form self-explanatory and only 17% (n=10) found the grant application process itself confusing. 61% (n=36) of respondents felt they received the technical support necessary during the grant application process. Also of interest is that a smaller proportion of respondents (49%; n=29) felt the grant decision making was transparent, with 31% (n=18) answering 'don't know'. Just over two-thirds of respondents (68%; n=40) felt that the grant streams have a strategic focus.

Some comments from respondents regarding the HPS application process included: "*Our partners in Gondar found the application form difficult to understand. They also found it difficult to understand the reasons for refusal," "The forms are complex to complete and time consuming. Some smaller charities are able to do really effective work for little money, but unless they tick the THET boxes with regards to specific outcomes then it is too difficult to apply," "There are phrases on the application forms that are not in common usage but have a specific use in the HPS. This can be confusing and therefore challenging to complete. It would be good to have a plain English oversight," "We had fantastic help from THET with our project plan and M&E processes,*" and "*Transparent process was not apparent as a Second Round application was encouraged and then declined as it didn't fit the criteria. Discussed this with THET."*

Table 13: Opinions regarding the HPS grant application process

	Agree	Disagree	Don't know	N/A
Information on the website and in HPS material is easy to understand and use	76.3% 45	6.8% 4	10.2% 6	6.8% 4

The grant application form was self-explanatory	78% 46	10.2% 6	5.1% 3	6.8% 4
HPS staff were helpful and knowledgeable	86.4% 51	0% 0	6.8% 4	6.8% 4
The grant application process was confusing	16.9% 10	69.5% 41	3.4% 2	10.2% 6
The grant decision making is transparent	49.2% 29	13.6% 8	30.5% 18	6.8% 4
We received the technical support that we needed during the grant application process	61% 36	8.5% 5	10.2% 6	20.3% 12
The grant streams have a strategic focus	67.8% 40	5.1% 3	20.3% 12	6.8% 4

When asked whether respondents had challenges during or after the application process, responses were varied and included:

- **Challenges relating to project design:** "*Difficulty in meeting some of the targets because some assumptions upon which they were based turned out not to be correct,"*
- **Challenges or comments relating to reporting and M&E:** "*Data collection is hugely challenging in countries that do not even have accurate hospital mortality statistics. In addition, I do not believe that just teaching formal courses with clear end points is necessarily the best way forward, support on the ground can have huge benefits but is more difficult to quantify,"* and "*Our biggest challenge came when the MELB document came out - neither our partners nor ourselves knew how to complete it."*
- **Challenges or concerns relating to grant selection:** "*We felt that we missed out during the last round (where we were shortlisted but unsuccessful) as there was no midwife on the selection team. Maternal and Newborn Health should be a priority for funding."*
-

Several respondents also stated that they had not experienced any challenges with regard to the application process.

Amongst unsuccessful HPS applicants only (n=12), perhaps not surprisingly, opinions regarding the grant application process were slightly more mixed. The majority (50%) found the information on the website easy to use and understand. Interestingly, 58% (n=7) found the application form self-explanatory but a similar number (42%; n=5) found the application process itself confusing. Responses regarding the level of transparency around decision making and the level of technical support received during the application process were fairly mixed (see below).

Table 14: Opinions regarding the HPS grant application process - amongst unsuccessful applicants only (n = 12)

	Agree	Disagree	Don't know	N/A
Information on the website and in HPS material is easy to understand and use	50% (6)	8.3% (1)	16.7% (2)	25% (3)
The grant application form was self-explanatory	58.3% (7)	8.3% (1)	8.3% (1)	25% (3)
HPS staff were helpful and knowledgeable	58.3% (7)	0% (0)	16.7% (2)	25% (3)
The grant application process was confusing	41.7% (5)	33.3% (4)	0% (0)	25% (3)
The grant decision making is transparent	16.7% (2)	25% (3)	33.3% (4)	25% (3)
We received the technical support that we needed during the grant application process	16.7% (2)	25% (3)	16.7% (2)	41.7% (5)
The grant streams have a strategic focus	41.7% (5)	25% (3)	8.3% (1)	25% (3)

HPS implementation process: The large majority of respondents (92%; n=43) felt that HPS fund disbursement was timely and efficient. When asked about HPS (THET) staff, 92% (n=43) felt that they were responsive, and 77% (n=36) felt that staff had good technical skills. Responses to questions regarding the flexibility of HPS funding were also reasonably positive, with 57% (n=27) disagreeing with the statement "there have been challenges in addressing emerging issues" and 60% (n=28) stating that the funding is flexible enough to respond to emerging needs. More than three quarters (77% (n=36) respondents felt that THET had enabled partners to adapt to changing circumstances.

Table 15: Opinions regarding the implementation of HPS

	Agree	Disagree	Don't know	N/A
Fund disbursement is timely and efficient	91.5% 43	4.3% 2	2.1% 1	2.1% 1
HPS personnel are responsive	91.5% 43	0% 0	6.4% 3	2.1% 1
HPS personnel have good technical skills	76.6% 36	0% 0	21.3% 10	2.1% 1

There have been challenges in addressing emerging issues	25.5% 12	57.4% 27	10.6% 5	6.4% 3
The funding is not flexible enough to respond to emerging needs	19.1% 9	59.6% 28	19.1% 9	2.1% 1
THET has enabled the partners to adapt to changing project circumstances efficiently	76.6% 36	2.1% 1	14.9% 7	6.4% 3
Monitoring data and reporting required by THET is too time consuming	31.9% 15	55.3% 26	6.4% 3	6.4% 3

Only 32% (n=15) respondents stated that they felt monitoring and reporting requirements were too time consuming and a number of interesting comments regarding the HPS implementation process were around reporting and M&E - and included both positive and negative statements:

"Our partners have an audit clerk who is great at collecting relevant data but could not understand the MEL document - he wants to have audit and data collection forms instead," "The M&E is very time consuming and difficult to do sometimes as a volunteer-but I think is necessary for good practice," and "*Reporting does take time and it would be helpful to have clarity on the reporting content for the whole project. Reporting is not disproportionate and at level expected for the amount of financial support we have. Monitoring can be challenging but we have had the ability to build in the capacity to do this in the project support so not a problem from that point of view."*

There were a couple of positive comments regarding THET, including: "*THET team have been excellent and very supportive.*" In terms of recommendations, one respondent suggested: *"Going forward, we think that it would be beneficial to develop some form of online reporting system for grantees." Another suggested: "There is a heavy focus on M&E and time could be better spent elsewhere. Perhaps an external agency covering M&E centrally funded would be good. Also some M&E could be replaced by good robust research that would be to the betterment of all health partnerships and therefore be an opportunity worth taking."*

Annex 10: Country Case Studies

Submitted separately

Uganda

Sierra Leone

Zambia

Myanmar

Annex 11: Remote Project Case Studies

11.1. A37 PROMPT Maternity Foundation

11.2. EB3 London School of Hygiene & Tropical Medicine

11.3. P1 NICE India and China

11.4. EA22 Kings Centre and Bas Congo Ministry of Health

11.5. F11 Sheffield University and Bayero University

Health Partnership Scheme Evaluation

Remote Project Case Study 1 – A37 PROMPT Maternity Foundation

Author: Georgia Taylor

Date: August 2016

SUMMARY

- Very effective project methodology and initial partnership (Mpilo Hospital), with high value for money.
- Strong national partner (ZCBC) commitment, but need for further partnership relationship development
- Potential for volunteering role and impact could be improved

1. Introduction

This project follows on from a previous HPS project (MPIP48), which was focused on improving maternal and newborn health in Mpilo Hospital in Bulawayo, Zimbabwe using the PROMPT methodology (endorsed by WHO). "*PROMPT provides simple, sustainable and locally relevant evidence based tools, with training to implement them in local hospitals, by local staff, for local staff. The training provides a vehicle through which simple 'safety tools' (eg early warning score (EWS) observation charts & emergency boxes) can be locally adapted, and adopted into practice*"[28].

The new project has a budget of £165,440 and runs from October 2014 for two years. It is a scale up of the approach in Mpilo to a further 31 health institutions managed by the Zimbabwe Catholic Bishops Conference (ZCBC). The UK partner is the PROMPT Maternity Foundation at Southmeads Hospital in Bristol.

Mpilo project background: Prior to the establishment of PROMPT at Mpilo, 79% staff had never having received any Obstetric emergencies training. Since November 2011, over 300 staff have been trained by local trainers. Over 87% staff at Mpilo have now attended training. In addition, safety tools and a Maternity Dashboard have been successfully introduced. These interventions have been associated with improved recognition and action in response to the unwell patient (4% to 73%), and a 34% reduction in in-hospital maternal mortality (740 to 476 per 100,000).

ZCBC are keen to run a parallel program to implement PROMPT in each participating unit. The project is cascaded to around 6 health facilities per province through five of the main ZCBC hospital, one in each province. Training and mentoring is delivered by Mpilo Hospital staff, international staff from Bristol and newly trained trainers in other hospitals.

2. Methodology

The remote study consists of review of project documentation and phone interview only, covering 3 people: PROMPT Maternity Foundation project manager and volunteer, the national partner from ZCBC and a short term volunteer. A further interviewee was not available. The THET project manager was also interviewed. Limitations – just a paper and remote interviews.

[28] Project application document

3. Findings

3.1 Effectiveness and impact

Figure 64: Demonstration of neonatal resuscitation by participants

The training has been rolled out successfully in three of the planned training locations, but the other two have been slower, with one hospital not engaging much at all. This is partly to do with unclear roles and responsibilities within the hospital between the ZCBC and the government officials – effectively creating two parallel organisational structures.

A total of 506 health workers have been trained so far. The plan was to train 16 health workers per hospital, but due to the low cost more were trained. Most of the hospitals are in hard to reach and rural areas where communications and transport is a big challenge. So it can be assumed that many hard to reach and vulnerable communities are being served.

The methodology has been demonstrated to change culture and behaviour among hospital staff. Now midwives and doctors get on well with each other and are friends. "*The information officer is so enthusiastic about the work that he is training others. We want to infect everyone so that they spread it*". (ZCBC Coordinator)

This project demonstrates a high level of sustainability through the approach of using local staff and trainers, firstly from Mpilo hospital and then further trainers are developed to deliver the training in the different regions. The national partner is clearly highly committed to the project implementation. "*We are thinking of expanding to government hospitals. We have given them a report and in some places we have trained the government officials that are sitting in our institutions and they assist us."* (ZCBC Coordinator.

However some of the key actors running the work in Zimbabwe are leaving – one of the midwives has moved to Botswana and the lead matron at Mpilo has just resigned. Also each hospital was supposed to have some health workers trained as trainers so that they would in turn cascade the training to other workers at the surrounding areas. The funds could not permit that. In the post training feedback, trainees have stated that the training duration was too short with very packed day, and they think it would have been better as a three day training. They also recommended that it should be held on a quarterly basis.

3.2 Partnership

Whilst the partnership between PROMPT and the Mpilo hospital was very successful and built over a number of years, the partnership with the ZCBC is new, and still in development.

According to the project document, learning from previous project demonstrated that one of the keys to the success of the "*partnership was the involvement of both senior and junior staff at Mpilo from the outset. The early involvement of the Mpilo Hospital Executive meant that staff were able to be released from clinical work to attend training and the inclusion of coalface staff meant that issues that were directly affecting staff at the coalface could be addressed. The involvement of Zimbabwean Diaspora from the outset of the partnership was also crucial*". (Project proposal document).

PROMPT and the ZCBC have different views about the success of the partnership and the pace at which PROMPT could withdraw as a partner. The ZCBC would rather continue implementation independently and does not see the value of continued contribution from PROMPT, whereas the PROMPT team have specific areas for development that they would like to complete before withdrawing. "*It is difficult when the partner is outside of the country. It is difficult to communicate with the partner.*" (ZCBC)

"We came to the UK for a symposium. When I heard what other countries were doing and what they were achieving it gave me the enthusiasm to try and do as much as possible. I have the objective to reduce the still births b 80% and Maternal deaths by 50%. This project has really improved things. In one hospital we have zero maternal deaths up to now since the beginning of the project" (Project coordinator ZCBC)

3.3 Relevance, alignment and ownership

A survey of ZCBC health facilities was undertaken in April 2014 and reported that many deaths could have been prevented through earlier referral, more adequate action, better equipment and training. In October 2014 ZCBC will commence a 3-year project in 31 health institutions to improve comprehensive healthcare through provision of solar power, safe drinking water and in-facility training for equipment maintenance. The roll out of the Mpilo pilot has been developed in response to this survey and resulting conversations with the ZCBC.

The Government has donor funds to implement lifesaving skills courses and BEmOC training, but "*this has not been well implemented and appears to be a top-down approach, with lack of transparency in the implementation of funds."* The government are not too keen on the role out of the PROMPT training in their own hospitals – which may reflect a belief that there is overlap with their own programme. Possibly more time should have been spent developing a relationship with government and MoH officials responsible for MNH. However the political and economic situation in the country is very challenging and it is deteriorating rapidly.

So while there is a good degree of relevance and alignment, ownership by government is not apparent. The ZCBC and Mpilo and participating hospital health workers are, however, very committed and there is a high level of ownership, with many health workers giving their time free of charge to train others.

3.4 Value for Money (VfM)

This project demonstrates a high value for money due to the very modest spend and the methodology that has resulted in phasing out the UK trainers and delivering the training all within the hospital. The training is low cost and likely to be more sustainable due to local ownership, skills and leadership. The international trainers are now only involved in training on the use of the dashboard, a recently run workshop in May for several hospitals. There is now a WhatsAp group among the national heath staff to discuss the use of the dashboard.

Some aspects of the financial management that the in-country team are struggling with. There is a need for support on the project management aspects. "Integrating processes between partners does take a while". However unlike other projects this project has managed to hand over some of the project management funds to the country partner to implement, but it is still fairly limited. "*Funds are administered in the UK and sometimes you need the funds and they do not arrive. We are normally sent the funds for training via Western Union. We received £4,000 last week for two hospitals that we had trained.*" (ZCBC coordinator) Also there is a large contribution in kind from the national partner: "*Because of the a limited resources through the project, PROMPT only funded training in 4 hospitals and the other 26 hospitals we funded ourselves. This is possible because the training takes place in the hospital, so it is low cost." (*ZCBC coordinator)

Delays in Cambridge Uni press in publishing the training manuals that had been adapted to the national context. They are doing it for very low or no cost – charitable funds.

The UK and the national partners demonstrate a high level of awareness of the cost effectiveness of the project and put in a lot of work making sure the costs are as low as possible.

They are running an underspend at the moment.

3.5 Volunteer and contribution to UK health system

The volunteers are all short term and do the visits in their own leave time. It is very difficult to get professional leave now due to the financial difficulties in the NHS. Their hospital in Bristol has just been put into special measures this week. However the hospital is very supportive of the development work of the PROMPT Foundation and allows health professionals to take leave. They see the value of it as the midwives and doctors who have travelled do come back with a different perspective on their own work. "*When we train within the*

hospital in the UK we give an update from Zimbabwe too – it gives people pride in the work and for them to see the importance of what we are doing. We have learned a lot from Zimbabwe that we are now using in other settings. For example I the Philippines and Laos". (PROMPT programme manager and volunteer).
All short term volunteering. They go and do some training and then it is left to the local team with support from the UK to run the cascades of training after that. The role of volunteers has not come out strongly in the reports. They don't give the names of the volunteers. 11 female and 5 male trainers went out throughout the whole 6 month period. It would be ideal if the same team could go out each time, but not necessarily easy with their own schedule.

The country partner values the volunteers, but now sees that the work can be done without them. "*They have provided good support for the project. But it is not really necessary for them to come. We have enough people who can carry on without their support. We can now do the training, even if they didn't come. Now they have given us the skills to do the fishing they don't need to sit by us to see if we are doing the fishing or not."* (ZCBC Coordinator)

"It is important as a volunteer to develop long term and trusting relationships. You can be much more effective if you build the trust over time. *Long visits are very important."* (PROMPT Volunteer)

Important attributes of a volunteer: enthusiasm, motivation, interested and willing to take the initiative. There is no right or wrong in terms of seniority – it just depends on the placement.

"It gives you confidence because you have to do lots of different tasks. Recently in Zimbabwe I learned a lot about chairing meetings. In the past in Malawi I gained leadership skills as I had to make decisions". (PROMPT Volunteer)

Preparation before the visit was just about the project and the partner. She (the volunteer) is already familiar with the culture and with volunteering. There was no political context or donor background given.

3.6 M&E

Data collection and use appears to be rigorous and systematic, though progress results have not yet been reported as the project is still ongoing. There is quantitative data collected in all of the hospitals, but qualitative data just in a selection of 6. Data, such as the dash board, is being used for management, change process etc. The training impact data is better than seen in other projects – it measures changes 9 months after training and also includes clinical observation.

Data to be collected in each of the four participating centres:

- Institutional questionnaire pre and 9 months post-PROMPT implementation (use of EWS charts, labour ward board, guidelines, training etc)
- Sexton Attitudinal questionnaire completed by 60 randomly selected staff pre and 9 months post-PROMPT implementation
- Snap shot audit of response to clinical observations pre- and every three months post-implementation of early warning charts
- Digitally recorded interviews of 8 randomly selected staff pre and 9 months post-PROMPT implementation
- Training database containing details of the staff facilitating and attending PROMPT training
- Maternity Dashboard data

There is a challenge however as hospitals are not always good at collecting and sending in data. *"Sometimes you go to the hospital to get the data, or you sit on the phone for a long time and it is challenging. Most of the hospitals have seen the value of the training. They also value the solar panels we have installed so that they have access to electricity. They see that we are working for the good of the people and they are more motivated to send the data to us. In some hospitals we have even put in internet so they can send by email."* (ZCBC Coordinator)

4. Conclusions and learning

This project is very effective and good value for money, with a high potential for sustainability. The key to this has been the strong partnership with Mpilo Hospital, a large teaching hospital (the second largest in the country), and embedding of the methodology and training capacity within that hospital. This has provided a national institution as an engine for change with ongoing support from PROMPT.

The partnership with ZCBC is fairly new and needs to develop further in order for a good level of trust and collaboration is built up. This might have happened more rapidly if there had been one or two long term volunteers placed in Zimbabwe to facilitate communication and ongoing relationship. It might also have been jeopardised by the large number of different volunteers going to the country.

5. Recommendations

- Spend more time developing the partnership with ZCBC
- Ensure government and other actors are aware of the successes of the methodology
- Use more long term volunteering – and a smaller number of repeat short term volunteers so that there is some continuity with the partner.

Health Partnership Scheme Evaluation

Remote Project Case Study 2 – EB3 London School of Hygiene & Tropical Medicine

Author: Paula McMeekin

Date: August 2016

SUMMARY

- This is an unusual project in that the LSHTM supports through this grant 12 partnerships between different UK and overseas organisations in 7 different countries.
- It is also innovative in its approach to focus on developing leadership skills, after identifying that this was the missing skill to promote real change within the overseas organisations. *"Anybody can be a leader. You don't need to be a manager. That was an idea that came across all the reports"* (UK project coordinator). Leadership and governance is also one of the pillars in WHO HSS framework.
- This project contributes, through its focus in leadership and communications skills, to the effectiveness of 12 existing partnerships, hoping to unfold some of the potential benefits of the broader programme they belong to: Vison 2020 links.

1. Introduction

Project data:

- **Project title:** Educator Development as a key to strengthening health partnerships and improving health outcomes.
- **UK partners involved:** London School of Hygiene & Tropical Medicine (LSHTM)-Lead partner;
- **Partnerships:** 12 Vision 2020 Links in 7 different countries:
  - Uganda: Makerere-Royal Free; Ruharo/Mbarara-Bristol
  - Zambia: Kitwe-Frimley
  - Tanzania: Muhimbili-St Thomas'; Mbeya-WHSC Altnagelvin; KCMC-Birmingham
  - Kenya: COECSA-RCOpth
  - Malawi: Blantyre-Glasgow&Liverpool; Lilongwe-Fife/Edinburgh
  - Nigeria: Lagos-Bolton; Calabar-Wolverhampton
  - Ethiopia: Gondar-Leicester
- **Project start-date:** 1st May 2015
- **Project end-date:** 30th April 2017
- **Budget:** £191,695

Project info:
This project supports 12 of the "links" or partnerships, working under the VISION 2020 LINKS Programme (which has 30 active links in total). This programme works with partner institutions in developing countries, mainly Africa, to promote the development of eye training "links" between NHS Hospital Trusts and other bodies such as the Royal College of Ophthalmologists. The general goal of this programme is to improve health outcomes through the development of sustainable health care services designed around locally identified needs and aligned with national priorities.

This 12 links involve UK organisations and organisations in 6 different countries: Uganda, Zambia, Tanzania, Kenya, Malawi, Nigeria and Ethiopia (full list above).

The overall project is managed by the lead UK organisation: London School for Hygiene and Tropical Medicine (LSHTM). The LSHTM is responsible, amongst other functions, for supporting the establishment and

functioning of the links, ensuring engagement of the appropriate Ministry of Health, promote learning and knowledge sharing between the different links and monitoring and evaluation of all the activities.

The project places a strong focus in developing leadership skills as these are believed to be key for effective service improvement. Other aspects of the trainings include needs assessment, clinical skills, service evaluation and organisation of the leadership workshops which are at the heart of this project. These aim to teach the behaviours and skills require to bring about whole system change.

The focus of the project is in delivering a series of workshops that will train trainers who will then be supported to deliver several trainings in their home institutions, with the aim of having 240 people trained in Medical Leadership and facilitation skills over the course of two years.

The project is based on the shared belief that the key factor for real system change in Africa needs to come from an improvement in leadership capacity, which will truly address the problems of corruption and flawed policy implementation. The project maintains that despite the many successes since the start of Vision 2020 links programme, the lack of leadership skills and the lack of facilitation skills to cascade learning are inhibiting real change. These two skills are key "to implement the inter-professional system changes required to translate the new learning into delivering real outcomes for patients". Leadership and governance is one of the 6 blocks in WHO HSS framework and it is sometimes believed to be a most neglected one.

2. Methodology

This remote study consists of review of project documentation (grant application, progress report Nov. 2015-April 2016, feedback from THET, financial report 12 months and project plan) and phone interviews with two UK project coordinators, one overseas lead (COECSA) and THET's grant manager.

3. Findings

3.1 Effectiveness and impact

Health System Strengthening

The project is based in the idea that the visibility of the trained facilitator outside the eye department will be enhanced and that this will benefit both the eye department and the wider institution. However, the change at impact level seems really difficult to measure in these projects.

Trainings

The project started with a 3-day workshop in leadership and facilitation skills for 2 people for each of the 12 links in Manchester. After that training, each pair run the another training for 8-10 people in their African Institutions. The participants of those trainings would then develop plans to improve services and also provide cascade learning (not training) themselves. "When thinking about who to select as participants for the cascade trainings we thought of staff of the MoH and graduate students that would use the leadership skills in different areas to achieve better health outcomes (e.g. how do we use our skills to promote change in our places of work?)" (COECSA, lead overseas partner).

The project has now concluded one full round of cascade training into the African institutions. In year two they will do the same thing again, with a new set of 9-10 people. This will imply reviewing their learning to improve effectiveness.

"The training in Manchester was well designed and well delivered" (COECSA, lead overseas partner)

By the end of the first year, the project had trained a total of 120 health professionals and management staff. See table below

Table 16: Workshop participants

Cadre – ALL 12 LINKS plus the PHD students group of five Total 120	No. of people of each cadre participating in workshops	
	Female	Male
OPHTHALMOLOGISTS	13	12
DOCTORS	3	5
RESIDENTS	7	3
Ophthalmic nurses	8	1
Nurses- general, midwives, paediatric, ob, surgical, A&E,OPD	21	13
Optometrists	1	8
OCO- Ophthalmic Clinical Officer	2	4
admin	5	3
Senior management	2	5
biomedical	0	2
observer	1	1
Total	**63**	**57**

Examples of effectiveness

Different links report on different activities and accomplishments according to their specific projects.

- The project co-ordinator then promotes sharing of these accomplishments amongst the 12 links which is a great platform for sharing knowledge and learning in different countries and organisations.
- One of these examples is the Patient Shadowing Journal for use in the Kitwe LINK which incorporates the idea of finding out the type of leader workshop participants are (which should impact the effectiveness of the trainings)
- There seems to be good senior level support that the project has gained in each of the 12 LINKS

Challenges to effectiveness

Some of the challenges identified across the different trainings in different countries have to do with the difficulty to get participants to attend the whole length of the courses (3 days) when these are delivered in the health settings. Apparently this is not an issue when the trainings are delivered in a separate hotel.

3.2 Partnership

All the 12 partnerships (links) supported under this project existed previously under the 2020 Vision Programme and some have a long time history. These are in general strong partnerships of which this project strengthens a small but important component around leadership and communication skills.

3.3 Relevance, alignment and ownership

This project(s) is part of the broader partnerships (links) already existing within the 2020 Vision Programme. This programme strives to make the country projects nationally owned and aligned with national priorities. The participants of the in country trainings are the ones who decide how to use the skills acquired to improve the effectiveness of their organisations in Africa. They do this based on their knowledge of the local context and local needs.

3.4 Value for Money (VfM)

The fact that lots of links (12) are managed by just two people from LSHTM (plus a medical student who provides some support) indicates good value for money. There are however lots of reports to manage. “It is sometimes too much for such a small time but only during the reporting work peaks” (UK project Co-ordinator) According to the last financial report, the total underspend of the project was £58,427.65 and although there were plans to increase expenditure but adding relevant activities (such a Review Workshop at the end of the project), the project is likely to struggle to spend the whole budget by the project end date.

3.5 Volunteer and contribution to UK health system

"The whole eye department want to have a link with a southern organisation" (UK project co-ordinator) so selecting volunteers for these projects is actually quite a competitive process. The links need to identify two priorities and agree that in the 3 years plan they will keep to those goals. This includes a commitment from the UK links people (volunteers) to go out either a) as part of their normal work (about a third of them) or b) on their own time (about two thirds of them). Some specialists find it easier than others to go as part as their work time.

"If you go through the 12 links you see different learning, sometimes depending on the type of professional. For example, more senior management positions, there was a learning about how to do good shadowing work as a way to build capacity. Very rich learning", "The nurses seem to take everything on board and report change and empowerment after the trainings". (UK project co-ordinator)

Benefits for the volunteers and the NHS:

- Learning about leadership skills is supposed to also benefit the NHS services by making its professionals more able to promote effective service improvement.
- Shared learning, for example "on how we organise our leadership and governance issues at COECSA" (overseas partner lead)

3.6 M&E

The UK project coordinator completes the THET progress report form every six months as agreed but do not submit to THET the individual links reports. "THET requires very detailed questions in the reports and often also after the report". (UK co-ordinator)

The links themselves need to fill out particular forms at each step of the way (e.g. after each training). One interesting approach of these reporting systems is that during the 10 people initial workshops in country, 2 of the participants volunteer to do the M&E during the workshops (e.g. to make sure that everyone fills out the forms, etc.) so that the person coming back to the UK can bring all required forms fully filled out and so that the work is shared and owned by various participants. (UK co-ordinator)

However, according to the communications between THET and LSHTM following up on the last progress report, three of the 12 LINKS did not report on outputs because this was not addressed with their workshop participants – Makerere, Lagos, Mbeya. "This will be rectified for Year Two." (Feedback letter to the 12 months progress report)

The final improvement in service delivery will be very difficult to measure. LSHTM hopes to be able to capture some of the change that is taking place in both of the institutions as a result of the project through a quiz that they do regularly.

3.7 Relationship with THET

The working relationship between the two organisations appears to be very good. LSHTM have had many grants with THET as part of the Links Programme. 4 of the 30 links currently have THET funding. Some LINKS have their own fund raising, and LSHTM also supports them in applying for other grants.

"Thank you to THET for being willing to take on this idea, because it is a very different idea and they have proven to be willing to be innovative. Wanting to do this in a small scale, we are really appreciative for that." (UK project co-ordinator)

4. Conclusions and learning

This is an interesting and slightly different project that focusses on the identified need to learn leadership skills as a foundation for effective service improvement.

It is indeed innovative and, although impact will be difficult to measure, it is a brave initiative that, because it is embedded within a much broader programme, has the potential to unfold many benefits for the overseas institutions. The benefits for the NHS are less clear as plans are not necessarily developed by the UK

volunteers to act on their home institutions. Although the leadership and communications skills acquired are expected to be a plus for any organisation.

It is encouraging to see these kind of investments in less traditional but incredibly strategic aspects of strengthening the health systems.

5. Recommendations

Some of the recommendations made by the overseas partner interviewed are:

- "I would first of all look at doing a baseline on what trainings people have had in future workshops"
- To have a small budget (£500-£1000) to support the cascading workshops (conference and refreshments, etc.). The generation 1 workshops are funded by the project, but no subsequent ones. (For COECSA it was difficult to get the space for the workshops, but he seems very aware of the need to keep costs down)
- Also some minimal investment to some of the projects initiated by the trained participants (e.g. support the reception area to improve the patients' management)

- Need to come up with an agreed way of measuring impact of the Vision 2020 Links. "Overall the Links project is replicable with outstanding outcomes, but it is not yet completely clear not clear how we are going to measure change: change in practice of the trainees? Number of patients? Number of trainees we train in leaderships?" (Overseas lead partner)

Other recommendations:

- It would be great to think of ways to measure change in the overseas organisations as a result of this project but beyond the length of it. Documenting this learning would be invaluable to replicate and advocate for this kind of initiatives in the future.

Health Partnership Scheme Evaluation

Remote Project Case Study 3: P1 NICE India and China

Author: Georgia Taylor (with reference to the Itad Evaluation Report of Jan 2015)

Date: August 2016

SUMMARY

- The NICE International project in India and China has seen to be effective in Kerala to develop and implement Quality Standards for MNCH.
- Partnership building and the establishment of wider partnerships has been successful and is ongoing.
- Project design and management have been challenging with insufficient re-design and significant underspends.

1. Introduction

P1 is a unique project in the HPS and is not part of any funding stream. It is the only project that works directly with research institutions and the public health systems in two of the world's most populous countries and important emerging economies through the National Institute of Health and Care Excellence (NICE) International.

The **aim of the project** is to ensure resource allocation decisions are evidence based and driven by a country–led, transparent, independent and inclusive institutions. The three project planned outcomes were focused on enhancing human resource and research capacity; supporting institutions to enhance evidence based decision making and developing stronger bilateral institutional links between NICE International (NI) and the wider UK NHS, and the healthcare systems in India and China.

The project was funded in 2012 with the initial intention of running a three year project with a budget of £954,370. Due to a slow start up and a significant underspend (50% by year three) the overall budget was cut to £783,119 and the project extended to a fourth year.

2. Methodology

This remote review is purely paper based and consists of a review of the Itad Evaluation of the project's work in India (Kerala) and a review of project budget and documentation. The project in India is a pilot to develop a Quality Standard (QS) for reducing maternal mortality in the state of Kerala. The evaluation took place 18 months into the implementation of the Quality Standard, which was launched in January 2013, in 8 pilot hospitals. The evaluation focused on collecting data for six indicators that were refined by NICE and Itad after the development of a theory of change during 2013 – 2014.

3. Findings

3.1 Effectiveness and impact

Training to implement the QS was provided in 6 pilot facilities by the KFOG and this was found to be of high quality, and led to changes in practice in the delivery and some general hospital systems such as improved record keeping. In one hospital staff "*also reported that training had helped in improving confidence and that there was less tension in the labour room"*.

However the training consisted of a one off training. A full training package had not been developed for the pilot facilities and this has limited the outcomes, sustainability and potential for scale up. There are some

exceptions though, for example the teaching hospital, where they have been able to integrate the QS into their education process and system – showing that institutional capacity and purpose effects the approach.

Sustainability is an issue as there does not appear to have been an institutionalising of the Quality Standard through Government Order in Kerala, nor of the broader mandate of evidenced-informed priority setting. However leadership of the training approach by the KFOG and the initiative taken by some of the facilities bodes well for a gradually institutionalised approach within the facilities themselves.

The evaluation only reported small examples of anecdotal evidence on impact on health services and women's health.

3.2 Partnership

While Nice International (NI) has a range of relationships in India and China[29], this sub-project has focused on building a relationship with the government of Kerala state. The project aims to pilot an approach for development and implementation of a Quality Standard for reducing the maternal mortality rate in Kerala and then expand and scale up to other states the partnership for this project is between NICE International, the Government of Kerala (GoK) and the Kerala Federation of Obstetricians and Gynaecologists (KFOG).

Many of NICE's partnerships are driven by personal contacts and the development of trust over time. This was deemed by the Itad evaluation to be an appropriate strategy given the context: "*The context to partnership building in India is heavily reliant on trust and relationship building as opposed to legal and contractual frameworks."* However "*NICE International's most mature partnership in India is with Kerala Federation of Obstetrics and Gynaecology (KFOG*)." (Itad Evaluation). This partnership appears to have developed and matured through the implementation of the project and is now well known nationally as an example of good practice of institutions from different countries collaborating in a complementary way towards a shared objective. It could be argued that, beyond trust, joint working, with tangible and concrete results, is the most important aspect of long term partnership development.

The development of the partnership with the KFOG and the Kerala government appears to have been strengthened by the widescale consultation of stakeholders in the development of the Quality Standard and the alignment with the national organisations' own aspirations and strategies. The effectiveness of the project would appear to be an important ingredient to the relationship and should possibly have increased investment in the short to medium term in order to scale up effectively to other states in India.

3.3 Relevance, alignment and ownership

This project was developed at the request of the Kerala Government and the KFOG and has been adapted from a pure evidence based policy and standards project to a policy and standards implementation. This adaption happened as a result of a realisation by the partners that institutions needed support in the implementation. It could be argued that NICE was not the appropriate institution for the implementation phase, as this is not their core expertise area, and they possibly could have worked with another UK organisation to provide this support. The quick adaption also meant that the implementation planning was not fully developed.

3.4 Value for Money (VfM)

The value of this project is not only related to the implementation of the QS, but also to the development of longer term partnerships with Kerala stakeholders and nascent partnerships with other states, such as Bihar and Odisha, both of whom wish to undertake a similar QS process. However it is not possible to undertake a full review of the VfM as this project is part of a wider funding scenario that involves other parts of DFID, World Bank, Rockerfeller Foundation and the Wellcome Trust. It appears that the budgets may not have been

[29] China: Directorate for Finance and Planning and the China National Health and Development Research Centre (CNHDRC), Ministry of Health, Ministry of Human Resources and Social Security and Renmin University

India: National Health Systems Resource Centre (NHSRC), Ministry of Health and Family Welfare, State government in AP, Maharashtra and Kerala, Administrative Staff College of India (ASCI) in AP, the Government of India Centre for Innovation in Public Systems and the India Foundation for Medical Research in Mumbai. NI also has links with the Public Health Foundation to form an India version of NICE and the South Asia Centre for Chronic Disease funded by the Welcome Trust.

associated with the HPS project full outcome areas and that complementary activity may have been funded by these other sources. This has led to a somewhat unbalanced expenditure.

Table 17: Total spend by January 2016

Expenditure Item	Actual spend	% of total
Project Management		
Non UK	£ 39,058.97	6.3%
UK costs	£ 460.11	0.1%
Equipment and refurbishment	£ -	
Travel		
Local	£ 9,664.30	1.6%
International	£ 363,146.11	59.0%
Training and capacity development	£ 16,672.42	2.7%
Monitoring and Evaluation	£ 186,716.78	30.3%
Total	**£ 615,718.69**	

International travel and M&E together account for 80% of the expenditure up to January 2016 – and only 2.7% of the total spend has been allocated to training. Given that the evaluation participants consistently reported that more training, mentoring and follow up was required in order to implement the changes required by the new QS, it could be argued that some of the travel budget could have been better used to institutionalise a training system within Kerala state, rather than bringing UK experts to India and vice versa. Ideally the whole budget relating to this project would have presented together – so that accountability was more straightforward.

Also there does not appear to be a full recognition of the importance of effectiveness and efficiency of projects in the partnership development process.

3.5 Volunteer and contribution to UK health system

There is no information in the evaluation about the use of volunteers or technical experts from the UK. There is some reference to the need for NICE to provide support to NI, so it does appear that NI is working independently of the UK NICE expertise. This means that the benefits that might accrue to the UK health system are possibly not maximised. The wider global linkages and networking, though, are a benefit to the UK health system.

3.6 M&E

Monitoring and evaluation accounts for 30% of the budget, which appears to be a little excessive given the size of the budget. It may well, though, be M&E that applies to the whole NI budget with their India and China work, funded through a range of different sources. A coherent project and M&E approach is essential for accountability and measurement of effectiveness.

4. Conclusions and learning

The implementation of the NI work in India bears very little relation to the original planned project that was agreed with the HPS in February 2013. Whilst the project partners had to adapt to context and take advantage of opportunities, it would have been better to re-submit the proposal with a well thought through project plan, and updated budget, once the changes had been decided.

However aspects of partnership and effectiveness that we are seeing in other projects are also relevant here – personal relationships and trust are important, but institutionalised relationships and effective project implementation are also important for both the development of the partnership and the outcomes and impact of the project.

The HPS were encouraged to fund this project by DFID and the decisions making lay outside of the normal HPS competitive process. The result is that some of the good approaches and best practice that THET has developed over the last 5 years has not been possible to apply in this project. Nor has the project design and structure leant itself to accountability and learning.

5. Recommendations

Over the last year of the HPS, THET should commission and write up a full case study of NICE International experience and achievements in China and India. The aim would be to learn for future work with China and India and also to develop NI's approach to international work and partnership further. Some of the budget underspend could possibly be employed to finance this.

In the future, if DFID or other government departments wish the HPS to fund initiatives that are outside of the designed processes, there needs to be a more rigorous assessment and design process in order to ensure the project adheres to THET's good practice models and learning.

Health Partnership Scheme Evaluation

Remote Project Case Study 4 – EA22 Kings Centre and Bas Congo Ministry of Health

Author: Paula McMeekin

Date: August 2016

SUMMARY

- This is an example of how small and strategic start-up grants can make new partnerships possible.
- With just £7,000 and 9 months of duration, two trips took place during which the partnership was further strengthened, two training courses in trauma and one in research were delivered, a trauma registry was developed and implemented and a promotional video and photos were developed.
- Very interesting "piloting" approach, relevant for a grant of this nature, where building relationships and learning from each other is the underlying key focus.
- Very strong commitment and involvement of the local health authorities. The Minister of Health for Central-Kongo is the local project coordinator, very aware, involved and supportive of the project.

1. Introduction

This is a concluded project funded with a small start-up grant (£7,000). It lasted 9 months, from 1st September 2015 to 31st May 2016.

The project was initiated by members of the UK Congolese diaspora who approached the Kings Centre for Global Health (KCGH). Two members of this diaspora also participated in the later prospection trip in May 2013, together with three people from KCGH. During their trip they visited three health institutions and met with the Ministry of Health for the province of Central-Kongo (then Bas Congo). A second visit was made in July 2014 by one person as the plans to establish a partnership progressed.

But the partnership did not take real shape until the grant was awarded.

The partnership aim was agreed with the Central Congo Ministry of Health and the Hopital General de Reference de Kikanda in Matadi, to improve health outcomes in the area of trauma care in the Central Congo province through trauma system development, trauma care and trauma research to impact clinical care. The project's initial focus was to develop and strengthen the partnership and to: i) develop a trauma registry (and pilot it initially at Kikanda hospital) to allow good data collection around injury and care in the province, ii) to train university students and staff in research and methodology and iii) to provide training on trauma care. For these activities the project would conduct two visits to the country.

Project background: Trauma is a major concern for the Ministry of Health of Central Congo province. The main road route running through Central Congo connects the Atlantic port cities of Boma and Matadi with the capital Kinshasa. The road traffic collisions are significant due to the high volume of traffic and the poor road safety. Although the scale of the problem has not yet been quantified in Central Congo, according to WHP (2013) road traffic incidents cause 1.24 million deaths annually with 91% of these happen in low and middle income countries. There are serious health facilities and health staff deficits to appropriately deal with the existing volume of trauma patients in the province.

The Minister of Health for Central Congo also believes that motorbike accidents have dramatically increased due to the generalized use of motorbikes as taxis. But there is no data available and planning at governmental level is still challenging.

2. Methodology

This remote study consists of review of project documentation (grant application, completion report, feedback letter from THET), one face to face interview with the project coordinator, several emails exchange with follow up questions and a phone interview with the Minister of Health for Central Congo (project lead overseas) and THET's grant manager. An interview with a project volunteer was attempted for several weeks but could not take place.

3. Findings

3.1 Effectiveness and impact

The project seems to have over delivered (all the activities planned and others), including in the initial project activities others requested by clinicians at Kinkanda (e.g. clinical posters for use in the emergency room)

Figure 65: Trauma registry development and implementation

The registry system has been established for case identification and data collection at Hôpital Général de Référence de Kikanda in Matadi. This is being piloted to check that the type of registry is appropriate for the local context. Feedback from local clinicians and Minister of Health was integrated and data has been collected since September 2015. At the time of the completion report (June 2016), there had been an initial database created and data entry for 35 cases completed. (Documents review, project coordinator and Minister of Health)

The idea is that the pilot at HGRK will inform the scale up in other health institutions in Central Congo and this idea seems to be strongly supported by the MoH at Province level. (Minister of Health Central Congo)

Primary trauma care course and Research methodology course

The project has delivered two Primary Trauma Courses[30], both in February 2016. They had 22 participants in Matadi and 21 participants in Boma and the initial feedback from the participants is good "*We have really learnt how to approach a patient who arrives with trauma. We have been taught a system that is very fast, very simple of ABC"* (trained nurse, Matadi).

Although the effectiveness of the trainings in terms of skills acquired cannot be measured at this stage (relatively early and no systems in place), it is very positive to highlight the "pilot" approach that the project brings in all its activities, very relevant for this type of start-up grants. With the training courses as well, there seems to have been a focus on "trying and learning" what is appropriate for the context, what is required and what is requested. These courses have provided the space for this valuable interaction and piloting between new partners.

[30] Photographs by photographer Zeke du Plesis, who joined the visit team in February 2016 (self-funded)

The project also delivered a half-day basic research methodology course for 110 students of medicine at the Université Joseph Kasa Vubu. Although a basic course, this also opened the door for future collaborations with the university and tested the appetite for this sort of trainings.

Partnership development

One of the key successes of this project is the development of a partnership that has now taken shape and gained strength through this initial project. There is a long-term and previous partnership (The King's Kongo Central Partnership), between the KCGH in London and the Kongo Central Ministry of Health. This partnership shares the same focus with the one established through this project (and started in 2012) between KCGH and Central Kongo Ministry of Health: to improve health outcomes in the area of trauma through trauma system development, clinical care and training.

Start-up grants do not usually include training activities and normally consist of one or a series of trips to the country for needs assessments and relationship development. However, this small project has managed to develop the partnership even stronger by delivering initial courses and developing systems while testing their relevance for the local context. This hand in hand work with the health clinicians and authorities, seem to have strengthened the mutual trust making this a partnership that is now thinking long-term beyond individual projects, despite the funding restrains. During the interview with the Minister of Health for Central Congo, and project coordinator overseas, Pf Mambu, it was very obvious her high awareness, involvement, support and commitment to the project. She even officially opened one of the trainings provided in order to show the participants the commitment of the Ministry of Health with this activity and the importance of taking the learning "in their hearts" to improve the health care delivered to patients injured in accidents (Minister of health central congo).

The project coordinator in the UK, Elizabeth Tissingh, has recently moved to DRC (self-funded) where she is going to be based for the next year supporting this partnership as a volunteer. She has taken a year out of trauma and orthopaedic training in the UK. This is expected continue strengthening the partnership further.

There was an application for a follow up grant (Knowledge Exchange & Sustainability Grants Round 2) where KCGH requested for £10,000 HPS funds to support the analysis of the trauma registry data and inform research, further integration use and potential scale up of the registry, further trauma care training and orthopaedic training and to support the current development of a website for the partnership. This grant was unsuccessful and the partnership is looking for additional funds while using some personal donations (from friends and family) to continue the ongoing activities (e.g. preparation of courses).

3.2 Relevance, alignment and ownership

The relevance test is part of the key components of this small grant. Through the different activities implemented, the project is testing to see what works and what does not, and UK partners focus on learning what is appropriate for the local context.

This buy in of the MoH, both a central and Central-Congo province level seem strong, with the Minister of Health of Central Congo being the main focal point and lead of the project locally. During a telephone interview, she confirmed that trauma and road accidents in particular, are both a priority nationally and in the province or Central Kongo. "Training the health staff that must know how to deal with injured patients is essential. This is a priority in order to improve the health of the general population. Essential to save the life of the people who have suffered accidents". (Minister of Health Central Congo)

3.4 Value for Money (VfM)

This project represents high value for money not only to "build" a partnership through collaborative work, but also to develop the registry system that, although being pilot only, seems to already be providing data that did not exist in the province just a year ago. This plus the initial two trainings provided in trauma care for just £7,000.

The scale up potential of this project makes it very interesting, particularly because of the strong buy in of the Minister of health for Central Congo who seems to be strongly backing these initiatives and is the lead overseas partner closely involved and supervising the project.

The UK project co-ordinator demonstrates a high level of awareness of the cost effectiveness of the project and costs have been kept very low as a result (e.g. accommodation during trips in guesthouses etc.).

Overall, the project spent £1,570 in course related costs in February (e.g. materials printing, courses' food and travel) and £6,472 in costs related to the trips done to DRC (e.g. 6 flights, visas, accommodation, food, communication, airport taxes, etc.). The difference of the total spent (£8,042) and this grant funds (£7,000) was funded by contributions made by friends and family.

The project also developed a short video and a set of professional photos done by a professional photographer who joined the visit team in February 2016 (self-funded). These are likely to contribute to fund raising for the partnership in the future.

3.5 Volunteer and contribution to UK health system

During the project, the volunteers have all been short term doing the country visits during their leave time and working on the preparation of the visits and the courses during their free time. They were identified mainly based on connections, people who knew people who had the skills, background and interest to participate in the project. The main project coordinator has now taken a year break in her training in the UK to go to DRC where she will be volunteering for this partnership and the follow up projects for a year. She realised that apart from the specific skills training, improving trauma care in Central Kongo will require changes in attitudes and culture, for which an ongoing presence, hand in hand work and on the job mentoring are required.

3.6 M&E

For this small grant, THET reporting requirements are lighter-touch than for the larger, longer grants. The project was only requested to provide a completion report (in June 2016) with an outline that "was easy to fill out and complete" (Project co-ordinator). At the time of our interview with the project co-ordinator (beginning of August 2016) they had not yet received any feedback or acknowledgement on their report.
Because of the nature of the project itself, there are no M&E systems in place, but the project team conducted a series of interviews in February 2016, to get the views different health staff who had participated in the trainings and were involved in the project.

3.7 Relationship with THET

The relationship with THET has been fine. The grant manager is very familiar with the project and the reporting requirements have not been a struggle for project management. The project coordinator would have expected a more dynamic communication with their THET grant manager, particularly regarding the submission of their completion report, but this may have just been delayed at THET.
The unsuccessful application for the follow up was hard on the project and the partnership (particularly after the good delivery of the start up grant) and there is a feeling that the feedback letter received did not sufficiently explain the reasons for the failure in their application. By the time of these interviews (beginning of August 2016) the project co-ordinator had requested a meeting with THET to get more feedback on this (as offered in their feedback letter of 13th July) and was waiting for an answer from THET.

4. Conclusions and learning

This project is a great example of how a small grant, well focussed can achieve the establishement and strengthening of a new born partnership. It proves that the "grant set up" schemes have, at least in this case, achieved its purpose.

There are however questions around "what's next". How these young partnerships can be sustained over time without appropriate funding? In this particular case, the unsuccessful application for an HPS follow up grant was hard for the UK partner, but their commitment has proven larger than the difficulties and, with personal savings, friends and family support, the volunteering will continue with a new long-term placement in the country to continue growing the partnership and delivering the project during the next year.

It is very early to see whether the initiatives started with this small grant (particularly the trauma registry development) and the government's commitment to scale it up, will end up growing and how effective these

will be. But the commitment and the relationship has been built, the personal and institutional professionalism is there with the back-up of a well-respected UK health organisation, and, with a bit of support, this initiative has the potential to dramatically improve trauma health care systems in the region and improve the quality of life of its population.

5. Recommendations

- For future grants applications, and despite the project is now completed and the UK coordinator may no longer be in the UK, it is still recommended to discuss with THET around the problems in securing the follow up grant (if possible). This is a good opportunity for learning around fund raising in the health partnerships domain and from an experience funds manager.

Health Partnership Scheme Evaluation

Remote Project Case Study 5 – F11 Sheffield University and Bayero University

Author: Georgia Taylor

Date: August 2016

SUMMARY

- Effective patient safety project with embedded diaspora volunteer and short term diaspora volunteers driving formal structure changes as well as changes in attitudes and behaviours in two teaching hospitals in Northern Nigeria.
- Slow build-up of ownership by hospital management, and good level of leadership in Bayero University.
- Project could be more effective if more long term and more focused.
- Learning: Baselines and monitoring need to include qualitative and confidential interviews to uncover the reality.

1. Introduction

This is a project between the School of Health and Related Research (ScHARR), University of Sheffield and the Department of Community Medicine (DCM) Bayero University Kano, in Northern Nigeria, with the support of volunteers from the Nigerian Muslim Forum UK. The goal is "*To build awareness on Patient Safety (PS) among hospital staff and strengthen surveillance of Hospital Acquired Infections (HAI) in Aminu Kano and Federal Teaching Hospitals Kano and Gombe".*

The project is funded under one of the HPS1.5 funding streams (F) which was specifically designed to address common health systems issues that had been identified during the first funding round of the HPS. All of the grants in the F funding stream are under £50,000. This partnership has not received HPS funding before. Their grant is £46,300 (increased to £57,000 for the LT volunteer) over 17 months from October 2015.

The partnership has been ongoing for a number of years as an academic collaboration. This grant has expanded the scope of the partnership's work to the health system in two teaching hospitals, which also forms part of one of their research agendas.

This project was designed to enable an empowering processes that involves hospital staff in the development of procedures and protocols for patient safety. It was to start with widespread interaction and discussion within the hospital and an iterative process between hospital staff and the volunteers that builds on the hospital capacity thereafter. The aim was to set up structures that would facilitate accountability and clarity of responsibilities around patient safety and to introduce new ways of working in the hospitals. This was to be supported by working on staff incentives, supervision and mentoring, innovative communications and a whole hospital approach.

2. Methodology

The remote study consists of a review of project documentation and phone interviews only, covering 5 people: Project lead and volunteer from Sheffield University, National partner and 3 further volunteers from the Nigerian Muslim Forum UK. The THET project manager was also interviewed. Limitations – just a paper and remote interviews and no interview with hospital personnel – so limited first-hand information about how the hospital staff have received the support and the changes.

3. Findings

3.1 Effectiveness and impact

Though the progress was slow at the beginning, the volunteers and the UK partner (interviewed only 10 months after the project start) all stated that there had been recent progress and that it was clear that attitudes and practice around patient safety were changing in both of the hospitals.

"You would want to see how things are going over time, and to bear in mind that individuals are learning a new concept. Definitely there is anticipation that behaviour has changed – definitely yes. You feel people's attention and idea to change what they do every day. In one of the units I felt that we were just there to reinvigorate their energy to remind them there is a different way to do what they do and to address their difficulties. The desire to engage has been impressive. I believe behaviour will change." (Short term volunteer)

Key progress includes:

- The appointment of a clinical risk manager with direct links with the hospital management and lines of accountability.
- Multi-disciplinary teams – infection control committee and medial audit commit
- New systems of accountability – such as each doctor now has a prescription code so that the pharmacy knows the source of each prescription.
- Incident reporting mechanisms and regular meetings on this – people are beginning to report
- Specific training and communications to change practice – e.g. hand washing
- The two hospitals are now producing their own anti-microbicide gel and making it available wherever it is needed.
- Started doing some clinical audits – looking at reasons for cancellations of operations, etc.
- Human resource management is improving – starting a mentorship programme for the residents. Also for a long time the consultants have been looking for a way of making their appraisals objective. they have finally found a way of doing 360 feedback.
- "*It is too early to judge – but I feel that being there for 3 months I have been really impressed with how they have embraced the project."* (Long term volunteer)

"It has changed the way patients are managed and the way patient safety issue are covered." (Bayero partner interview)

"Most of the time it will take a long time for behaviour to change. Most of the people are talking about it, but it is too early to tell. We did do a baseline survey and monitoring is ongoing, and we still have to pull the data together. But through discussions we can definitely see that there has been a change in knowledge and attitudes. The volunteers have been in the hospitals, telling us how they do it in the UK. That in itself will ginger you to change your practices. Especially when you know what you are doing is not good enough." (Bayero partner interview)

Sustainability

Sustainability in the hospital is not yet necessarily assured. There is some concern that the project is too short and maybe not focused enough to really embed the change. It may have been more effective to focus on just one hospital with such a limited budget. However the volunteers are planning to stay engaged at their own expense and in their own time, and will also try to raise funds to continue the work. At a state and national level, there is potential for wider learning and scale up, but this also needs some further input through a national conference and through the University curriculum.

"Also we plan to start teaching patient safety at the university, including it in the curriculum, through one of our doctors who has been involved with the project." (Bayero partner interview)

"Through this project the partners wish to catalyse a national dialogue on patient safety, an area of health that has very little attention in many low and middle income countries. They will hold a national conference in

March 2017 and present the results of their work. We intend to spread the word about patient safety and hospital acquired infections. Talking to management of other hospitals so that they can pilot such schemes and see if they can scale up. You don't just eat alone, you also invite your neighbours to share your food – share your experiences." Bayero partner interview.

Reaching the most vulnerable

The project areas covered a range of ethnic groups including the Fulani (majority of Gombe), Bolewa, Tera, Tula, Kanuri, Dadiya, Waja and Tangale, all in Gombie and Hausa and Fulani in Kano. Gombe and Kano are in the most deprived parts of Nigeria, with 70% poverty rate in Gombe state[31]. The volunteers reported that the hospitals supported the poorest to receive services through a special fund, a relative's camp and waiver of fees in dire cases.

3.2 Partnership

Though the partnership between Sheffield and Bayero University already pre-dated the project (since 2010) and there had been some previous and ongoing academic (an MSc in public health) and research collaboration[32], the project had never worked before with either of the hospitals. It has not been straightforward and the relationship with the hospital and trust has had to be built up gradually. Also, because the Bayero Department of Community Medicine is the partner, there is not a direct link with the hospitals. However as Bayero and Sheffield have been developing these links and relationship with the hospital together, it should have a long term impact on the expertise in the Patient Safety sector in Nigeria. This will depend on the ongoing commitment of Bayero and the ability to develop their internal capacity.

The partnership with the Nigeria Muslim Forum UK (NMFUK) is also important as the volunteers were contacted through them. The NMFUK already organises placements for Nigerian diaspora health worker, but not normally through such ambitious projects. The Sheffield University lead was already involved with the NMFUK and both Bayero and Gombe teaching hospital have connections with the NMFUK.

There were differing opinions among the volunteers about the commitment of Bayero University and the support given to the project, and this appeared to develop over time.

"They could have taken more of a responsibility for the project than they had. I think probably one of the difficulties they had was that the partnership was with the public health dept. in the University and they seemed quite detached from the clinical side, which is where the project was going to be. Particularly in Kano. They did not have much leverage over the key stakeholders needed to engage. I don't think they showed a lot of interest in the project. In the later part of the project they had one of the lecturers helping to coordinate the activities. In the initial stages we had to do a lot of the ground work. Though we had expected Kano to be more challenging as it is a bigger institution." (Male short term volunteer)

"To be fair to the Bayero staff, the second time we went they were a bit more prepared and a bit more receptive, so the professor of community medicine was the one who enabled my connection with senior staff of the departments. And all of the heads of departments. The dedication of the clinical risk manager who is also on the infection control team. He was instrumental in liaising with the nursing department. We got more numbers of delegates to the training the second time around. They really did help me." (Female, long term volunteer)

According to Bayero, the partnership is of great value to them. *"We are now viewed as the champions of patient safety and for public health and I am proud of that. it also improves the image of the department and*

[31] 2013 National Bureau of Statistics Nigeria

[32] There is an ongoing collaborative work between the two institutions to establish a Centre for Health Systems Research at BUK to be funded by the Nigeria's Tertiary Education Trust Fund (TETFund) to consolidate the different research programmes. There are currently five academics from BUK at different levels of completion of doctoral research (funded by BUK's internal funds) at ScHARR using the new research framework and focusing on the different priority areas identified in the research agenda developed by the network. This summer, two additional doctoral researchers from BUK (one on Commonwealth scholarship) will commence study at ScHARR, one of which is on strengthening patient safety in the obstetrics department of the BUK's partner teaching hospital (Aminu Kano Teaching Hospital - AKTH).

the hospital. The partnership with Sheffield also gives the whole university a better image and reputation." (Bayero partner interview)

Relationship with THET

During the inception meeting we were given good orientation on monitoring and evaluation by THET staff. They also provided link to resources such as survey tools, websites of similar initiatives and individuals that provided useful advice. The webinar was also very helpful as specific questions related to challenges in implementing the project were answered. THET staff were also very responsive to email queries. These have been reassuring and helped us in adapting our plan to meet project objectives. For example, the flexibility around project management budget allowed us to meet in the UK and this has helped us make progress on a number of project activities and we hope to have a similar meeting towards the later part of the project. (From the Sheffield University months 1 – 6 report March 2016).

3.3 Relevance, alignment and ownership

The project was started by a request from Gombe hospital to the UK partner through personal contacts and also through the long term relationship with Bayero University. Bayero did the situational analysis with multi-disciplinary teams from the hospitals, so there has been a good degree of ownership by the national partner. However, "*the hospital staff were a bit suspicious of the process, possibly thinking that the hospital management was trying to catch them out*" (Bayero partner interview). So when the volunteers started working directly with the hospitals, they found a wider variety of issues to address than was originally identified.

As well as a number of areas for improvement in the hospitals, the scoping identified that there are no hospital, or state wide guidelines or protocols for infection control or patient safety, even though there appears to be some interest among state level governments. *"If you ask government they will say that patient safety is a priority, but you don't see much attention given to it – in fact there is no attention. If anything the people in power do not want to provoke a scandal by uncovering the reality in the hospitals."* (Bayero partner interview).

Using the situational analysis the project design was undertaken through an extensive online discussion among partners. The chief medical directors and the chairpersons of the medical advisory committees of both hospitals had also actively participated in all the meetings and agreed to the priority areas selected.

"The situational analysis conducted in the two tertiary hospitals reveals major constraints to patient safety including lack of dedicated funding (not a regular item in annual hospital plans), skill and personnel shortages and lack of access to clean water. A major priority is to bring patient safety to the top of the agenda of the leadership and health professionals and make it an integral part of service delivery. This project will therefore focus on raising awareness on patient safety and improving surveillance in the first instance." Project proposal 2015.

There was no awareness by the UK partner of any other donor or DFID projects in Nigeria, though the national partner did have some awareness of how the project was relevant to and could complement other initiatives.

3.4 Value for Money (VfM)

All of the project funds to be spent on activities in Nigeria (e.g. training, workshops) are channelled through Aminu Kano Hospital. *"It is just venue, refreshments, questionnaires for the baseline and transportation of participants, not anything to do with the volunteers as that is taken care of by Sheffield."* Bayero partner interview.

Expenditure in the first six months came in just 7% over budget, which is a small variance compared to the other projects, which indicates that the project management and monitoring of the budget is fairly good.

The overall value for money is very high given the time volunteers are giving to the project. Also the potential for whole hospital impact (though it is still a work in progress), and the potential for influencing state and federal level work on patient safety for such a modest budget indicates high value for money. The budget and expenditure so far shows that more has been spent on training (23% compared to 19% of total) and on international travel (23% compared to 15% of total) than planned and less on the management costs (15% of total spend), which is probably a good thing as the original plan was to spend 21% of the budget on

management. This reflects the extra effort that was required by the volunteers at the beginning of the project to engage with the two hospitals as reported in interviews.

Table 18: Project expenditures

Expenditure Item	Total budget	% of total	Actual spend	% of total
Project Management				
Non UK	£400.00	1	£618.00	3
UK costs	£9,070.00	20	£2,951.07	15
Equipment and refurbishment	0		0	
Travel				
Local	£3,600.00	8	£1,558.79	8
International	£7,200.00	15	£4,402.21	23
Accommodation and subsistence	£9,870.00	21	£3,253.48	17
Training and capacity development	£8,800.00	19	£4,400.00	23
Monitoring and Evaluation	£6,160.00	13	£2,250.00	12
Communications materials	£1,200.00	3	0	
Total	**£46,300.00**	**100**	**£19,433.55**	**100**

"There is a high chance of change if they (the hospital staff) continue with this trajectory and not lose momentum. I will come back again at the end of November to continue the training by myself. It feels a bit premature to leave the project – we have just started putting the structure in place and there are parts of the WHO patient safety curriculum that would strengthen their clinics' risk management structure and quality improvement. And I would like to see whether the small changes are making them advance forward. They need that. We did apply for further funding to come back in November but we were unsuccessful. So I have taken it upon myself. I have been meticulous in spending the money for these expenses and I have some money that I can use." (Female long term volunteer)

If we hadn't got this grant, we would just have continued as normal. Patient safety would have just remained in the background. There would still have been the closed infection prevention committee that existed before, but it would have remained underdeveloped and not useful. (Bayero partner interview.)

When asked whether he would choose the project or the partnership he said *"what a tough choice, how can you ask that. It is like asking a child to choose between its mother and father. The young child will not be blamed if he chooses his mother as she gives him food, but as the child grows up he will see that his father is equally important."* (Bayero partner interview).

3.5 Volunteer and contribution to UK health system

All of the volunteers and the Sheffield project lead are diaspora Nigerians. This is thought to be a huge benefit to the effectiveness of the project (confirmed by all interviewees). There is also the perception that it would have been very difficult to recruit volunteers to visit Northern Nigeria because of the security situation (both of the hospitals are in states with recent security issues) and the need to speak Hausa. The diaspora volunteers know the culture and the health system context, and are perceived to possibly have a higher level of motivation. *"I am not saying that British volunteers are not wanting or useful for helping. But if you are from Nigeria, your zeal will be much higher than someone who isn't."* (Bayero partner interview).

This project started off planning to only have 4 short term volunteers making 2 – 3 visits in total. However when THET offered ongoing projects some additional funding for a long term volunteer placement, the team realised that this would give them the opportunity to have more of an impact within the hospitals. They had found that the short term visits were not sufficient and when they returned for the second visit it felt as though they had never been before – nothing had changed and they had to start the process all over again.

One of the volunteers decided to stay for 3 months (May – July) and that experience has been a great success for her and for the project. However her employer would not approve a sabbatical so she has had to resign

from her post at Kings. The other two volunteers have fit their Nigeria visits into professional leave, which, for one of them, has to be paid back either side of the visit in extra working sessions. Their employers (Gloucester NHS Trust and Poole Hospital in Dorset) expect information and presentations from the volunteers so that others in their hospitals can learn from their experience. There is a great deal of interest.

Both of the short term volunteers had plans to continue to work with the two hospitals in Nigeria. One of them will continue to engage on a personal capacity – limited more to his speciality (consultant surgeon), *"There are certain things I wanted to do more of, around surgical checklist, safety concerns in theatre, systems handling of sharps, that need a bit more time and that we couldn't do."* (short term volunteer).

The other volunteer wished to develop a partnership through his hospital. *"My hospital has a charity called the Poole Africa link in S Sudan and are interested in looking at other countries. Now things are changing in Nigeria. They might be willing to look at that."* (Short term volunteer)

All of the volunteers are motivated by wanting to "give something back to their country of origin" and felt comfortable working in Northern Nigeria. They also have enough seniority and mix of experience between them to cover the technical areas required by the project. There is only one woman (the long term volunteer) and she has not suffered from any discrimination or disrespect, though sometimes her Nigerian counterparts have considered her young for the level of expertise she has. She has worked well with senior hospital staff and has responded to ongoing challenges in the hospital by encouraging a systems and more long term response as issues arise. "*I did act as a role model. I was invited to give a lecture at the Nigerian Medical Association conference last week. And I was the only woman speaker. Afterwards several of the lady doctors came up to me and said that they were proud to see a lady speaking and it gave them confidence to do the same*". (Female long term volunteer)

"*Having the opportunity to stay for the 3 months gave me an insight to the various challenges and the clinical issues that they (the hospital management) face. A lot of the issues came into the deputy chief medical officer's office - so we developed protocols and guidelines as we went along as the incidents kept coming. It opened my eyes to the high rates of maternal mortality. As an acute physician I am interested in prompt emergency care. It has fuelled my passion to complete my training. My background in clinical governance and clinical risk management has helped me to develop an organogram to set up the patient safety team, the roles and responsibilities. This has really benefitted me – developing and using my teaching skills, increasing confidence in speaking in public. Learning to be sensitive to get things done.*" (Long term volunteer – 3m)

"A huge thank you for DFID and THET – it is a dream to me. I have been thinking for a long time about how I could contribute something to the Nigerian health sector. This project and the support we got from the donors to make this dream a reality." (Female long term volunteer)

3.6 M&E

This project has used some interesting baseline and monitoring tools and has integrated learning about the effectiveness of data collection as the project has developed. For example the baseline did not give a full picture of the issues – and the quantitative data did not tie in well with the follow up qualitative data that was collected. There are issues about confidentiality and trust that influence data collection. So the two universities have ensured that rigorous qualitative data is collected as part of monitoring.

4. Conclusions and learning

- The use of diaspora volunteers, and the combination of short term and long term volunteers, has been the cornerstone of the project's success
- Sustainability and scale up will rely on the continued efforts of the university and hospital staff to fully integrate and institutionalise the new protocols, structures, processes and behaviour change – and this may need further support.
- The potential for national scale up will need more funding and networking support from THET and other national actors (such as DFID and other health donors).

5. Recommendations

- Systems change projects such as those working on patient safety should have a longer timeframe and should be encouraged to think about focus and feasibility in relation to budget.
- More work with Diaspora organisations would be interesting – especially for countries and areas where there are security and language issues.
- Longer inception and partnership development periods should be planned into the project, and also consider how best to use long term volunteering to support the development of relationships and to encourage change.

Annex 12: Summary- Literature Review of Volunteering Reports

Key points from documents:

1. **Elective Engagement Final Report**
   - aim of the Elective Engagement programme is to increase awareness of and commitment to global health and development issues amongst clinical students and communities in the UK with a particular focus on diaspora communities
   - two elements, the Elective Aid programme and the Global Health Ambassadors programme
   - Elective Aid programme involved 15 medical students spending 4 weeks in Bangladesh, 11 students identified as Black and Minority Ethnic (BME) and 7 were female
   - All demonstrated a significant increase in their understanding of and dedication to global health as a result of their placement
   - Global Health Ambassadors programme trained 100 medical and health students to become advocates for tackling one of four challenging global women's health issues: Obstetric Fistula, Female Genital Mutilation, HPV and Cervical Cancer, and Mental Health and Stigma
   - 70% of the volunteers on the Global Health Ambassadors programme are female, and 66% of volunteers identify as BME
   - The pilot programme made good progress against its indicators, meeting or exceeding them in all but one case – however, indicators were simply number of activities conducted, number of people reached by activities, and self-reported increased awareness, therefore difficult to gauge real impact

2. **Review of Norwegian Esther /FK Health Exchange Programme**
   - FK Esther's overall goals are to contribute to solving the health personnel crisis and reaching the Millennium Development Goals related to health by strengthening the education of health personnel and delivery of quality health services in countries where Norway is engaged in long term development cooperation.
   - It supports institutional cooperation and capacity building, through exchange of personnel within institutional twinning arrangements between health institutions in Norway and in the South, primarily in Africa and consists of 12 projects.
   - Strengths include: perceived as beneficial on both sides of partnership, changed professional attitudes and better motivation, believed to strengthen health systems, some reports of improved working with patents of different cultures in Norway.
   - Weaknesses include: lack of overall strategic direction – disparate projects, short project cycles, monitoring gaps
   - Opportunities include: flexible approach and responsive to partners, overall long term perspective for collaboration exchanges
   - Threats include: potential gap if funding not continued or scaled back, difficult to justify if monitoring not improved to focus on results

3. **LSTM: Benefits of NHS staff volunteering overseas**
   - Study commissioned by the Director of the Sanyu Research Unit (SRU) at the Liverpool Women's Hospital (LWH) in order to identify the individual and institutional benefits and challenges of NHS staff volunteering overseas.
   - Only 8 people interviewed, 7 doctors, 1 midwife – 2 fully funded, 6 part funded
   - **Individual experience:** generally very positive, life-changing personal and professional development, skills enhancement across many domains, satisfaction from perceived life-changing impact on individual patients, some reported meaningful research and innovations.
   - **Challenges:** frustration with the scale and nature of the challenges faced overseas, concern about the long-term sustainability of their interventions, loss of pay, pension contributions and annual leave though many willingly contributed these.

- **Institutional experience:** LWH has a very positive attitude towards volunteering and sees it as a way for staff to develop and bring new skills back to the organisation, staff return with enhanced confidence and motivation, pride in being involved in international work, release of staff through a flexible approach, non-volunteers can feel involved through making a financial contribution and by hosting overseas visitors.
- **Challenges:** managing work during staff absence, managing long-term assignments, re-integrating staff after long-term assignments, managing volunteers.
- **Recommendations**: appropriate selection, induction and monitoring and evaluation process; Volunteer skills should be formally assessed after long term placements; purpose of any visits and the objectives of any partnerships should be clear; projects should follow a quality improvement methodology with SMART goals to improve sustainability; volunteering should be within a CPD framework.

4. **Health Education England (HEE) Toolkit for collection of evidence of knowledge and skills gained through participation in an international health project**
   - Seeks to provide NHS staff and employers with a framework for recording their skills and competencies achieved as part of their international health project and to reflect on how these can be best applied when they return to work;
   - Links to the NHS Knowledge and Skills Framework (KSF) for annual appraisal, the NHS Healthcare Leadership Model (2013) and the requirements of the Royal Colleges for accreditation of international project work for Continuing Professional Development (CPD) and revalidation;
   - Covers three domains - Knowledge, skills and performance: Quality Assurance: Communications, partnership and teamwork: and uses reflective practice to consider what happened, their experience and role in what happened, why it happened and what they might do were the same things to happen again;
   - Uses a before- and after- self-assessment form with 6 areas answered on scale of 1-10 and includes: communication, personal and people development, equality and diversity, service improvement, project management, developing leadership skills.

5. **Draft Paper on Promoting NHS overseas volunteering by a new pension scheme**
   - A proposal for incentivising volunteering overseas through an affordable, sustainable, NHS-led pension contributions scheme;
   - Loss of pension contributions is a significant deterrent to “unfunded” overseas volunteering by NHS staff - the cost of making self-funded additional contributions has risen;
   - Currently HPS volunteers can apply to stay as contributing members of the NHS pension scheme on the basis of their pre-departure salary with contributions being paid on their behalf by a central Government funded scheme but wholly DFID-funded and finite so not sustainable;
   - The present proposal is to establish a new NHS-led scheme which leverages existing contributions from NHS employers for a new fund open to non-HPS volunteers;
   - For **£1m** pa (cf total NHS pay bill of £44 billion pa ie 0.0023%) the NHS could provide pensions support for **716** such volunteers.

6. **Improving Global Health (IGH) report – Evaluating the impact of returned fellows**
   - The Improving Global Health (IGH) through Leadership Development programme is a unique and innovative scheme run by the Thames Valley and Wessex Leadership Academy (TVWLA). Since 2008, 150 NHS employees from a range of healthcare professions have completed an IGH Fellowship (typically 6 months duration), working with an overseas partner organisation, in a resource poor setting;
   - The aims of the programme are to: support sustainable improvement in healthcare; provide an unparalleled personal and leadership development experience, and create a cadre of skilled leaders who will apply these skills on their return to the UK (study focused on this last aim);
   - Fellows complete a bespoke pre-induction programme which includes: leadership development, project planning and evaluation, teaching and learning, public health and quality improvement

methods; and are supported on placement by an in-country and UK-based team, including a dedicated mentor;
- Response rate was 70% with 75 respondents, 70% doctors, 87% female;
- There was an overwhelmingly positive perceived impact for the majority of respondents and even Fellows who had found their overall experience was not what they hoped, still received some positive benefits;
- Specific areas mentioned include better leadership skills, improved work attitude and motivation, career opportunities, increased confidence, greater awareness and appreciation of different contexts and values, multidisciplinary working, more able to reflect;
- Recommendations to IGH include encouraging more diversity among volunteers (more non-doctors); longer duration of volunteering (at least 6 mths); greater clarity pre-departure on roles & responsibilities and areas of work; greater clarity on reporting requirements; more support on return to use new skills in NHS and more opportunities to continue working in global health.

7. **SEED Global Health Report**
   - Seed Global Health, founded 4 years ago, with flagship program — the Global Health Service Partnership (GHSP) which is a joint initiative with the US President's Emergency Plan for AIDS Relief (PEPFAR) and the Peace Corps;
   - Aim is to address a critical need by sending nurses and doctors to work in countries with crushing burdens of disease compounded by crippling shortages of skilled health professionals and empower the next generation of health professionals;
   - Embeds GHSP Volunteers as Nurse and Physician Educators — working alongside local faculty at partner nursing and medical schools;
   - Over first two years in the field, placed 72 Volunteers, who have taught over 300 courses and trained 7,219 nursing and medical students, post-graduates, and hospital staff;
   - Many of the people trained have become passionate and effective teachers themselves, sharing lifesaving knowledge and skills with other students and hospital staff;
   - Partner institutions and faculty are leveraging the support to strengthen health systems, reinforcing academic curriculums and clinical services in specialities ranging from family medicine to cardiology and pulmonology;
   - Also provides support to upgrade facilities and equipment, and ongoing mentorship;
   - Currently in Tanzania, Malawi and Uganda and plan to expand to 2 more countries in 2016;
   - Again, impact is measured only in numbers of people trained, etc. – no evidence of other performance-related data.

8. **iDSI Health systems strengthening in low and middle income countries: UK partnerships at the systems level (v useful report but more on general partnerships than volunteering)**
   - Outlines considerations and potential approaches for UK state sector organisations to systematically collaborate with low and middle income countries (LMICs) for health systems strengthening in response to International Development Committee recommendation for DFID to establish a clear strategy for how the UK government should work in partnership with the NHS to support overseas health systems;
   - Recognises the important contribution of volunteering but focuses on systematic, long term dedicated partnership and technical collaboration between the UK health system and LMICs at the systems level as potential avenue for UK to be stronger advocate for Universal Health Coverage;
   - 24 key informants were interviewed from a variety of organisations including the NHS, central government departments and executive agencies, nongovernmental organisations, royal colleges, and academic institutions;
   - Considerations included the nature of the activity, geographical remit and working in middle income countries, accessing sustained funding, and measuring results with the most consistently raised issue being **coordination** between UK state sector organisations;
   - **Criticisms of current partnerships include**: commercial drive to 'sell' NHS and supply-driven; fragmented approach with overlap/duplication; volunteering model promotes provider level activity

rather than systems level; unclear capacity in UK to respond to demand for systems level and longer term partnerships and to systemise learning from other settings to UK;

- **Principles of partnerships** should be: demand-driven, country-led, appropriate to context, grounded in needs assessments, recognises the political economy in the partner country, partnership principles, co-development and mutual learning, collaborative, additionality and sustainability, quality assured;
- Aspects of the UK health system most commonly described as strengths were: education and training; priority setting including standards, guidelines, and health technology assessment; professionalism and revalidation; regulation; governance and accountability; information systems; primary care; public health and global health security;
- Collaborations were also noted as a way of potentially improving the effectiveness of traditional ODA spending, as UK health institutions could also partner with multilaterals such as the GAVI, the Vaccine Alliance and the Global Fund to Fight Aid, Tuberculosis and Malaria (GFATM) on areas such as priority-setting of interventions to be funded;
- Characteristics that were desired for any funding modality were that it is: flexible, longer term, optimises use of a broad range of funding sources and grants, has sustained political will behind it, and, some suggested, provides funding beyond voluntary activity, to include staff engaged in a substantive way;
- The importance of a clear governance structure delineating 'commercial' and 'philanthropic' work was highlighted;
- Concerns were raised about the use of Official Development Assistance (ODA) to fund this work which might limit scope of countries to DFID high priority ones whereas majority of the world's poor now live in middle-income countries. Many of these middle income countries are still on the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee (DAC) recipient list but are not the lowest-income or fragile and conflict-affected states that are the bilateral ODA priority for the UK;
- Recognised that although a demand-driven approach may not be primarily based on need, it suggests political will and desire for collaboration. This in turn would impact on the likelihood of sustained, locally-led change;
- **Capturing impact requires** the use of measures that allow flexibility, including flexible logframes, and qualitative indicators to capture the nuance and complexity of collaborations;
- **Risks identified include**: pushing a UK model where not appropriate, reputational risk of appearing fragmented or commercially-focused, lack of sustained financing, further stressing of already stretched NHS;
- **Six main approaches were outlined**: a consortium of state sector institutions; development of a centre with cross-cutting expertise; a managed fund for systems-level partnerships; a social enterprise approach; a regional approach harnessing academic health science networks; or provision of small development assistance budgets for individual organisations. The risks associated with each approach need to be carefully considered;
- A clear **vision, strategy and theory of change** for technical collaboration for health systems strengthening in LMICs across UK state sector organisations would guide activity through defining the purpose, priorities and desired impact. An overarching strategy that is informed by empirical evidence on the nature of demand for collaboration could provide a clear purpose and enhance coordination, and draw together the various strands of work currently ongoing;
- The DFID framework on health systems strengthening that is currently being developed may address this. More work is needed to assess which approach is best placed to respond to demand aligned to this framework, and if more than one may be appropriate, or a combination of approaches.

9. DFID GOSAC UK Partnerships lessons Learned (v useful report but more on general partnerships than volunteering)

- Collates some of the lessons learned from 6 existing institutional partnership programmes: the HMRC Tax Capacity Building Unit; the Health Partnership Scheme (HPS); the Investment Facility for Utilising UK Specialist Expertise (IFUSE); Legal Assistance for Economic Reform (LASER); National School of Government International (NSGI); and Rule of Law Expertise (ROLE UK).

- Focuses on three discrete elements of the partnership programmes: Operating Model (overview of the basic parameters of the contracts, the cost structure and resources available), Strategy (purpose of each partnership programme; its approach to sourcing supply and demand for assignments; and the institutional incentives to encourage participation.), and Performance (approaches to monitoring and evaluation; how programmes demonstrate development results and assess the value for money of their activities; and how the delivery partner has performed).
- No primary evidence was collected or evaluated.
- **Lessons learned - Operating Model:**
    - Partnerships programmes are likely to benefit from having an ambitious stated duration: preferably a minimum of 10 years even if for practical purposes initial funding can only be guaranteed for a shorter period as there is considerable initial investment in setting up programmes;
    - administration has proved more burdensome where there is confusion between related, but different terms: outputs, results, milestones, and performance;
    - Payment-by-outputs can work, but needs careful designing so as to enable flexibility while also minimising administration;
    - DFID's delivery partners are at their best when they have relationships among UK institutions, credibility (through their teams) in both development and technical matters, and the established operational and financial capacity to deploy funding at scale. New ventures are unlikely to achieve this unless they explicitly absorb existing delivery units;
    - A common approach to accounting for the costs of partnerships programming is needed, in order to enable easier comparison between approaches;
    - It may be beneficial to identify good practice for logistics arrangements (for example on **HPS** or **IFUSE**) and scale them up rather than creating new logistical units.

- **Lessons learned – Strategy:**
    - There are similarities across the six programmes in the actual co-benefits that accrue to UK institutional partners and their people, but differences in the way they focus on them and measure them - should consider building an overarching framework of impact evaluation, common to all partnerships programmes, and which reflects both development and strategic impacts;
    - A significant scaling up of future programming is feasible from supply side;
    - On demand side, it is worth investing time during the design phase to identify ready opportunities that can be taken once implementation begins;
    - Experiences with DFID Country Offices have been mixed, with the best ones focused on active collaboration (one element of a wider Country Office strategy or programme) or consent (at a strategic, thematic level only);
    - For 'consent' model, a future programme would need to have a designated point of contact within each relevant CO, with assigned (and resourced) responsibility for UK partnerships;
    - There is a delicate balance between being 'demand-led' and 'strategically focussed'. Actively concentrating opportunities within a manageable number of priority countries enables an initiative to build its expertise and networks and can deliver better quantity and quality of supply and better cumulative impact. A critical mass of assignments in a given country helps to justify a dedicated partnerships resource permanently stationed in country. This in turns helps facilitate new partnerships and gives valuable local insight into political economy and institutional appetite for reform.
    - Clearly defined parameters can be helpful in guiding management teams and wider stakeholders as to what is within, and outside, the scope of a future programme, e.g. definition of institutions (include CSOs?) and the additionality of the mechanism (compared to traditional TA mechs).
    - Different institutions will have different motivations for participating in partnership programming. A typology could be helpful to have a clear sense of what political, commercial or financial incentives are at play for their institutional partners, so that they can interact accordingly;
    - It is reasonable to assume that if all six programmes operated under a common brand which was explicitly linked to UK institutions, the sum would be greater than the parts - a strong and

cohesive communications and marketing plan could add significant value to a future programme.

- **Lessons Learned – Performance**
  - No two programmes are identical and therefore it is not feasible to create a standard Theory of Change and logframe that can be applied to every partnerships initiative. Nevertheless, it may be feasible to create an overarching framework that creates a common understanding of what should be placed at the output and outcome levels and what kind of metrics DFID's delivery partners should be expected to report progress against;
  - Data now available on the performance of these six programmes could be used to inform realistic expected results and enable more beneficiary metrics to be included;
  - Overarching frameworks need to reflect the fact that not every programme has a mandate solely to engage directly in partnerships activities but may also include e.g. improving partners' programmes or influencing donor policy;
  - The experience of HMRC illustrates the critical role for DFID in ensuring that future programming gives governmental institutions access to the development expertise they need to complement their technical expertise;
  - Formal mid-term evaluations enable DFID and other stakeholders to consider the longer-term impacts of their programmes and present an opportunity to optimise the design of their interventions;
  - Future programming may benefit from being opened up to the full range of assignments – short-term, long-term, conferences, and so on and the M&E system of such a programme could reflect this typology. Guidance on the costs and benefits of using different approaches could be offered to the various Institutional Partners and partnership actors in order to help them consider which modality may have the best chances of success in a given context;
  - A future programme could also benefit from a more thorough unitisation methodology that enables a fair comparison of different initiatives in terms of their cost per assignment and cost per deployed day;
  - This unitisation model will provide the basis for a better understanding of economy but there is also a need for better metrics to understand the efficiency and effectiveness of partnerships programmes.

10. WHO Partnerships report

- Evaluation of African Partnerships for Patient Safety (APPS) - which aims at strengthening patient safety and Infection prevention and Control (IPC)at the national and hospital level through hospital-to-hospital partnerships, supported by ministries of health and WHO regional and country offices;
- Currently there are almost 100 members of the APPS network spanning 39 countries – this report focuses on 5 NHS organisations and their 5 partners in Africa;
- Describes the perceived and actual value that hospital-to-hospital partnerships add and whether, and to what extent, such a model can stimulate the spread of patient safety and IPC improvements beyond immediate partnership hospitals;
- Higher objectives include: building the necessary resilience to ensure that hospitals can withstand shocks such as those posed by the recent outbreak of Ebola virus disease in West Africa; developing stronger and safer health systems and service delivery essential for universal health coverage (UHC) to become a reality; and providing effective, efficient, high-quality, safe and person-centred health care delivery to protect the world from the threat of antimicrobial resistance;

- **Key findings:**
  - Sustainable, tangible improvement in patient safety and service delivery has been noted across all partnerships with an emphasis on structures and processes as well as development of hospital policies, and the strengthening and in some cases establishment of training programmes. The APPS model provides a robust framework in support of multi-professional involvement, and offers a structured way to align the philanthropic, volunteering work that health partnerships are built upon with a hard edge of strategic work related to patient safety and quality improvement. The APPS approach unites disease-specific

programmes and health systems and has the potential to strengthen front-line country-level responsiveness;
    - The greatest return on investment is realized when partners have access to high quality, easy-to-use technical resources alongside partnership collaboration to support local improvement;
    - Partnerships provide a vehicle for dialogue that generates ideas and opportunities, influenced by the vision of the programme, to address the multiple barriers to improvement;
    - APPS has contributed to strengthening patient safety processes in the NHS, particularly noted in relation to the development of leadership skills, resource awareness and problem-solving capabilities;
    - The partnerships appear to have acted as a catalyst for change, influenced by a combination of WHO facilitation, local energy and commitment, and national acknowledgement of the importance of patient safety work, within a supportive, facilitative framework;
    - However, limited data on patient outcomes.

- **Key recommendations:**
    - Support the emerging drive for national patient safety policy and strategy in the African Region, including funding, and leverage benefits to the NHS (and European) organizations;
    - Promote hospital-to-hospital patient safety partnerships as a vehicle for addressing some of the critical global health challenges of our time related to resilience, UHC, people-centred health care and antimicrobial resistance;
    - Continue to address inequities, barriers to affordability, and impediments to supply and distribution of essential IPC products in Africa;
    - Develop a comprehensive communication and dissemination strategy to enhance spread of knowledge in this emerging field of enquiry;
    - Build on community engagement findings to maximise potential, particularly around patient safety as a rights-based issue.

Key points to highlight in HPS report:

Benefit to volunteers:

- Almost without exception volunteers report personal transformative and highly positive experiences in areas like leadership, confidence, greater awareness about global health, problem-solving, innovating in difficult circumstances, improved attitudes to patients.
- There is no clear evidence that diaspora volunteers are more likely than others to be more effective but in one study they were much more likely to volunteer (1).

Success factors in volunteering:

- Appropriate selection, induction and monitoring and evaluation processes;
- Clarity on roles and responsibilities, purpose of visits and objectives of the partnerships;
- Volunteering should be within a CPD framework;
- Facilitative institutional environment and flexible approach in enabling absence from workplace;
- Facilitative administrative aspects, like pension contribution.

Benefit to UK health system:

- Returned volunteers have positive attitudes and greater understanding of backgrounds/ context of patients from LMICs;
- They bring new skills back to workplace and report using them;
- They provide a good link from NHS to global health area as many get involved in local events and campaigns, etc.;
- They promote a positive reputation of NHS abroad;
- They help strengthen links between institutions and promote understanding on both sides.

Success factors in partnerships:

- Longer duration (at least 6 months) is thought to be more effective (6) though other reports don't mention any negative effect of short duration stints;
- Hospital-to-hospital partnerships very effective and can stimulate much broader changes in partner countries (7, 10);
- Local energy and commitment, and national acknowledgement of the importance of partnership;
- Flexible approach and responsiveness to partners;
- Being able to show tangible results is more likely to result in further funding;
- The greatest return on investment is realized when partners have access to high quality, easy-to-use technical resources alongside partnership collaboration to support local improvement.

Recommendations for future partnerships:

- A clear **vision, strategy and theory of change** for technical collaboration for health systems strengthening in LMICs across UK state sector organisations would guide activity through defining the purpose, priorities and desired impact but need to balance this with a demand-driven approach – this is a delicate balance;
- Consider creating an overarching framework that creates a common understanding of what should be placed at the output and outcome levels and what kind of metrics DFID's delivery partners should be expected to report progress against;
- Consider operating partnerships under a common brand which is explicitly linked to UK institutions - a strong and cohesive communications and marketing plan could add significant value;
- Projects/partnerships should follow a quality improvement methodology with SMART goals to improve effectiveness, results-focus and sustainability;
- Long term perspective for collaboration exchanges is needed;
- More support for volunteers on return to use new skills in NHS and more opportunities to continue working in global health;
- Very few partnerships can demonstrate impact: this requires the use of measures that allow flexibility, including flexible logframes, and qualitative indicators to capture the nuance and complexity of collaborations – need to go beyond reporting numbers of people reached and look at outcomes for beneficiaries;
- A common approach to accounting for the costs of partnerships programming is needed, in order to enable easier comparison between approaches.

Relation to questions/issues you mentioned:

- *Is it more likely to impact on UK health system if the partnership and volunteering is hospital to hospital – through a permanent set of staff?* **Not specifically examined but indications are that it is the institutional arrangement that matters more than a permanent set of staff and hospital-to-hospital partnerships work well but not specifically compared to other types of partnerships.**
- *Are diaspora volunteers more effective as they know the local culture and can develop more permanent, longer lasting linkages to the other country?* **No real evidence of this but not specifically looked at in comparison to non-diaspora vols.**
- *Is there a difference in long term and short term volunteering?* **See above but again, no real comparisons of long vs short.**
- *How does volunteering help the UK to link with the Global Health community going forward?* **Some comments on this above**

Annex 13: Instruments

Information on instruments will be submitted separately